November, 1957

Canadian Hospital

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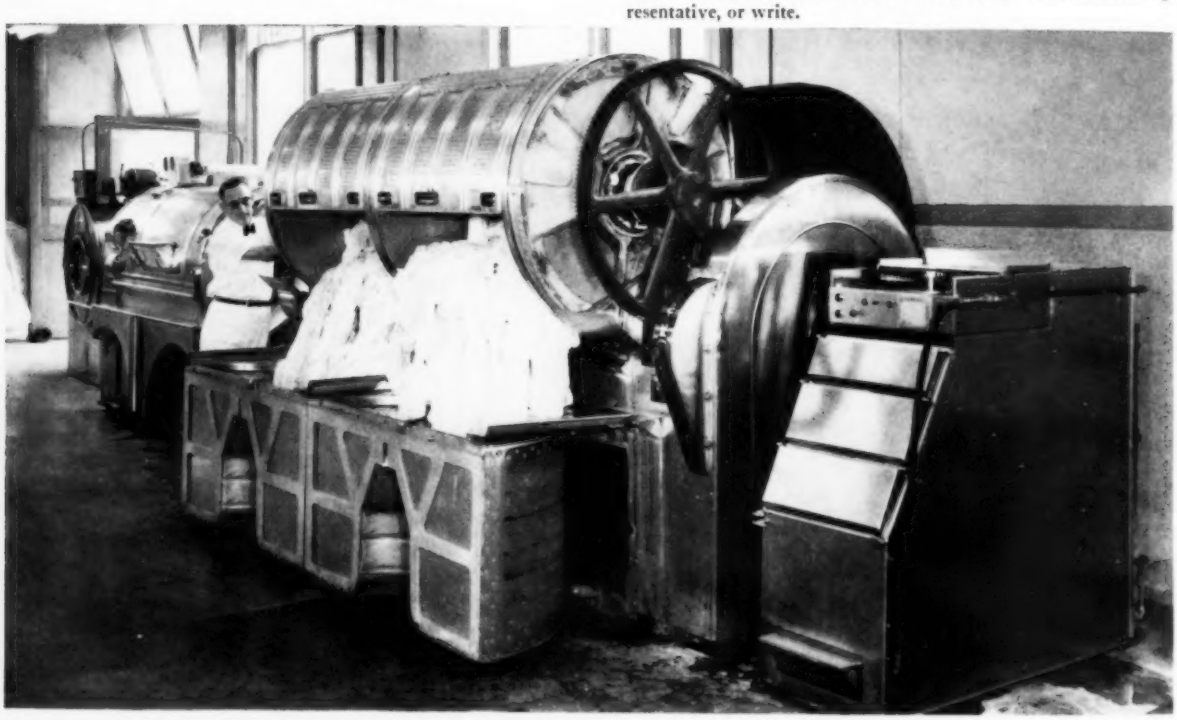
Canadian Hospital Association

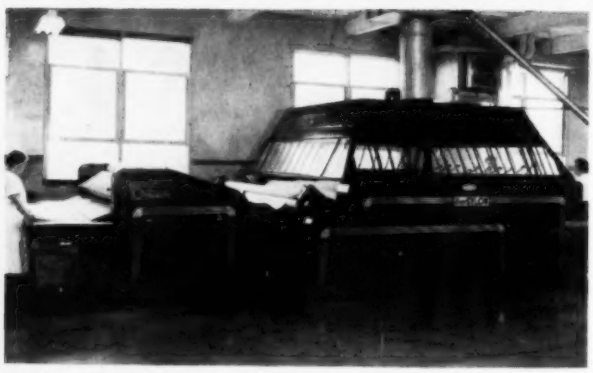
Report from Brantford General Hospital, Brantford, Ontario

Laundry costs down $600 per week with modern Canadian labor-saving equipment

Now, at the 378-bed Brantford General Hospital, pushbuttons handle former backbreaking laundry chores—thanks to new Canadian equipment. Automatic controls regulate work, practically eliminate manual operations. This adventure into modern, efficient laundry techniques has paid handsome dividends. Production is up 40%—weekly volume approaches 11 tons. At the same time, labor costs have dropped *$500 per week!* Added to this is a $50 weekly savings in supplies, better quality work, improved working conditions and faster return of linens to service. This is one example of what Canadian laundry planning and automatic machinery can do. For complete information, contact your nearest Canadian representative, or write.



Press buttons and 350 pounds of washed work tumble automatically into waiting containers of Notrux Extractor. These Cascade Unloading Washers, equipped with Full-Automatic Controls, now in use at Brantford General Hospital, are the ultimate in labor-saving equipment. The controls automatically perform 59 separate operations of the washing cycle—without attention.



Automatic folding of all linens reduces operating personnel and increases flatwork ironer production in Brantford General Hospital's efficiently planned laundry. Trumatic folder *(left)*, at delivery end of 8-Roll Super-Sylon Flatwork Ironer, automatically folds both large and small pieces, neatly and uniformly, at highest ironing speeds.

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The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

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Contents

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Business Manager: Charles A. Edwards
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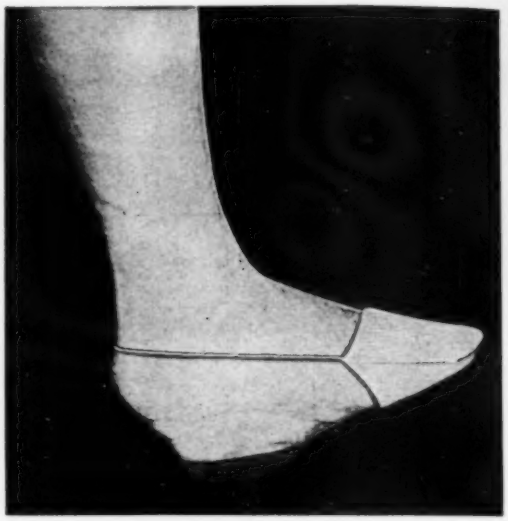

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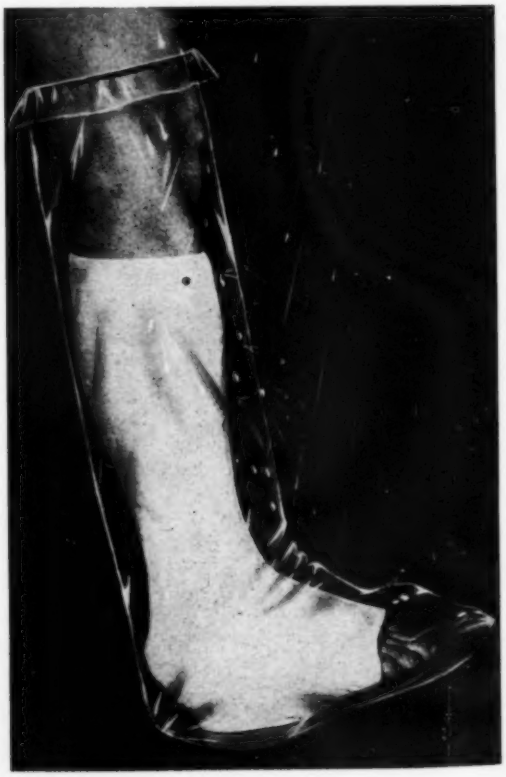

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Notes About People

Legal Adviser in Trinidad

The services of the Department of National Health and Welfare's chief legal adviser, Robert E. Curran, Q.C., are to be made available to assist the government of Trinidad in revising its public health legislation. Mr. Curran has recently completed a preliminary survey of the situation and will return to the West Indian island later in the year to begin work on the assignment. He is the writer of "Canada's Food and Drug Laws" and is honorary solicitor to the National Heart Foundation, the Canadian Cancer Institute and the Canadian Association of Radiologists. On the international scene, Mr. Curran has represented Canada at a number of U.N. conferences.

Administrator for South Waterloo

F. B. Gadsby has been appointed administrator of the South Waterloo Memorial Hospital, Galt, Ont. For the past four and a half years Mr. Gadsby has been assistant administrator of the Kitchener-Waterloo Hospital in Kitchener, Ont. He has also had experience as assistant to the chief accountant at the Hospital for Sick Children, Toronto, Ont., and was associated with hotel administration for the British Railways in his native England.

Appointed to Children's Hospital

C. F. Matheson, administrator of Colchester County Hospital in Truro, N.S., for the past six years, has accepted the position of administrator of the Children's Hospital in Halifax. He is a native of Dartmouth and lived there most of his life, with the exception of six years' service in the Royal Canadian Navy.

In 1957 Mr. Matheson began the Canadian Hospital Association's course in Hospital Organization and Management. His appointment with the Children's Hospital was effective on November 1st. He succeeds Franklin H. Silversides, who resigned to accept a position with the Department of National Health and Welfare in Ottawa.

Staff Changes in Prince Rupert General Hospital

Edward H. Knight, of Vancouver, has been named administrator of the Prince Rupert General Hospital, Prince Rupert, B.C. Mr. Knight, formerly assistant administrator at the Vancouver General Hospital, Vancouver, B.C., now fills the position left vacant by the resignation of Arthur Rutherford.

Walter Zet, accountant at the Prince Rupert General Hospital, has tendered his resignation and will be succeeded by Milton Barrow.

Robert W. Longmore

Robert W. Longmore, assistant superintendent of the Toronto General Hospital, Toronto, Ont., which he served for 36 years, died on September 28 at the age of sixty. He had been ill since June.

A native of Woodstock, Ont., Mr. Longmore had lived in Toronto since the age of nine. He joined the staff of Toronto General Hospital in 1921, and later became assistant superintendent, a position he held until his death. A member of the American College of Hospital Administrators, he had long been active in the work of the Toronto Hospital Council, as well as serving on various committees of the Ontario Hospital Association and the Canadian Hospital Association.

Always friendly and quietly good-humoured, Bob Longmore will be remembered as a leader by his associates and many personal friends in the hospital field.

Robert W. Longmore

Glaswegian Flies to Sudbury

Angus Maclean, M.C.F.P., recently appointed physiotherapist at the Sudbury Memorial Hospital, trained at the school of Physiotherapy at Glasgow, Scotland. He has had considerable experience in hospital and clinical work, including plastic surgery, orthopaedic rehabilitation, and athletic clinics. Previous to flying to Canada to assume this new position, Mr. Maclean was employed at the Royal Infirmary, in Glasgow.

Other Appointments at Sudbury Memorial

Edith H. Chapman has been named director of nursing at the Sudbury Memorial Hospital. She succeeds Dorothy Monteith, who recently enrolled at the University of Western Ontario to study for a Bachelor of Science degree. Miss Chapman has been associate director of nursing at the hospital since August of 1955.

Frances A. Wilson, formerly of Children's Hospital, Halifax, N.S., has commenced her duties as medical record librarian at the Sudbury Memorial.

A. Torrance is now laundry manager for Sudbury Memorial. His laundry experience includes three years as laundry manager at the St. Catharines General Hospital.

Dr. N. L. Hoffmann Receives New Appointment

Dr. Norbert L. G. Hoffmann has been appointed assistant pathologist to the Regina General Hospital, Regina, Sask. Dr. Hoffmann, after receiving his medical degree in 1934 from the University of Breslau, came to Canada in 1951. He has served on the resident staffs of the Grey Nuns' Hospital, Regina, and the University Hospital, Saskatoon, as well as the Regina General Hospital.

In his new post, Dr. Hoffmann will assist Dr. J. D. Stephen, chief pathologist and director of laboratories there.

North Battleford Has New Superintendent

Dr. I. Haniffy, M.B., recently assumed the duties of superintendent at Indian Hospital, North Battleford, Sask. He replaces Dr. Cameron Corrigan, who is now at Manitowaning on Manitoulin Island in Ontario. Dr. Haniffy joined the Indian Health Service in 1955 at

(continued on page 18)

A NEW DIMENSION IS ADDED

In the past, in the manufacturing of major surgical lighting fixtures, a compromise between design affording highest surgical illumination efficiency and fixture maneuverability was always inevitable. It is well established by most surgeons that the repositioning of the fixture for optimal illumination during advancing phases of the operation cannot be as accurately effected by the anaesthetist or circulating nurse as by the surgeon or his assistant. Now the designers of the Super Hanaulux, in conjunction with recommendations and suggestions made by Dr. Robert Coffey, Chief Surgeon of the Georgetown University Medical Center, have developed the new Super Hanaulux Model C. The Model C permits the focusing of the light by the surgeon or his assistant without breaking sterile technique.

The detachable handles of the Model C can be removed for sterilization. The basic design of the Super Hanaulux light head, widely acclaimed by surgeons as offering the most advanced field illumination features and performance, has been maintained. Illumination intensity can be varied, depending on operative requirements. Fully color corrected, with field size variable, from 7″ to 15″ in diameter.

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Notes About People

(continued from page 12)

Fort Qu'Appelle Indian Hospital where he served until going to North Battleford.

John W. Cavers

John W. Cavers, a victim of acute leukemia, died in his sleep on September 25. For the past ten years Mr. Cavers had served as administrator at Wesson Memorial Hospital, Springfield, Mass. He was 46 years of age.

Born in the United States, he moved to New Brunswick at an early age where he received his education and business training.

Mr. Cavers had been an accountant for several years at the Toronto East General and Orthopaedic Hospital in Toronto, Ont., and had then served as business administrator for the Oshawa General Hospital from 1941 to 1945.

He was Massachusetts member in the House of Delegates of the American Hospital Association.

New A.H.A. Officers

At the annual convention of the American Hospital Association held in Atlantic City, September 30th to October 3rd, president-elect Tol Terrel of San Angelo, Texas, was installed as president. He succeeds Dr. Albert W. Snoke of New Haven, Conn. Ray Amberg, director of the University of Minnesota Hospitals in Minneapolis, is the new president-elect.

• Mrs. Esther L. Spencer has been appointed administrator of the Huntsville District Memorial Hospital, Huntsville, Ont.

• Frances McQuarrie has resigned from the post of nursing education secretary of the Canadian Nurses' Association in Ottawa, Ont. Miss McQuarrie has returned to her native province of British Columbia where she has accepted a position with the Registered Nurses' Association of that province.

• Sister Teresa Agatha has been appointed recently to the office of administrator at the Sault Ste. Marie General Hospital, Sault Ste. Marie, Ont.

• Irene Shaw, who resigned from Bowmanville General Hospital, Bowmanville, Ont., has taken up the duties of director of nursing at the Ontario Hospital in North Bay, Ont.

• G. A. Cox, formerly administrator of the Groves Memorial Hospital, Fergus, Ont., has now assumed the duties of assistant administrator at the Kitchener-Waterloo Hospital, Kitchener, Ont.

• Dr. David R. Brown has succeeded Dr. H. E. Robertson as superintendent of the Essex County Sanatorium at Windsor, Ont.

• Miss E. Midlege has been appointed superintendent of the Lady Minto Hospital, Cochrane. She succeeds Willamene R. Allan who has been appointed director of nursing at Port Colborne, Ont.

• Mrs. Gladys Gordon succeeds Jean S. Paterson as superintendent of the Nipigon District Memorial Hospital, Nipigon, Ont.

I firmly believe that all doctors should study human nature and, if they wish to fulfill their obligations, should search diligently for the relations between man, his food, his drink, and his entire mode of life, and should search for the influences which each exerts on each.—*Hippocrates.*

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C.A.M.R.L. Annual Meeting

The 23rd Annual Meeting of the Canadian Association of Medical Record Librarians was held on September 16th, 17th, and 18th at the Nora-Frances Henderson Hospital and St. Joseph's Hospital, Hamilton, Ontario. With delegates from as far east as Antigonish, Nova Scotia, and from Victoria, British Columbia, in the west, all provinces were well represented.

On the opening day Ada Squires, R.N., superintendent of the Nora-Frances Henderson Hospital, welcomed the members. The Right Reverend J. A. O'Brien, D.P., pronounced the invocation. In her opening address Margaret Heenan, R.R.L., president, outlined the year's activities, chief among these being changes in the by-laws to be proposed, and the details of membership in the International Medical Record Federation. The members were guests of the city of Hamilton for luncheon, at which greetings on behalf of the city were extended by Controller Ada Pritchard.

Two papers comprised the afternoon program. Laurette Koleff, representing a commercial firm, gave an enlightening talk on the phonetic system of filing. Joanne Ashley, medical photographer and illustrator at Hamilton General Hospital, explained some aspects of her work and showed slides to illustrate her contribution to teaching and research.

When tea was served at Mount Hamilton Hospital members had an opportunity to renew old friendships and to make the acquaintance of new members.

On Tuesday morning Dr. J. B. Neilson's paper on "National Hospital Insurance" provoked much thought and discussion. Dr. Neilson is second vice-president of the Canadian Hospital Association, a member of the Ontario Hospital Services Commission, and is superintendent of the Hamilton General Hospitals. Gordon J. Sullivan of the law firm of Sullivan, Sullivan, and Shea spoke on the "Medical Record at Court". The many questions asked showed how keenly interested the members were in these remarks.

Tuesday afternoon's session closed with a panel on medical records. Those taking part were Sister Mary Grace, R.N., superintendent of St. Joseph's Hospital, acting as moderator; Dr. A. J. Liston, general practitioner; Dr. M. Phin, assistant superintendent, Hamilton; Morris Thurston, secretary-treasurer of Morden and Helwig Limited, Insurance Adjusters; and Dr. Margaret McGuire, R.R.L., Winnipeg General Hospital, Manitoba.

Dr. W. J. Deadman was guest speaker at the banquet held at the Royal Connaught Hotel. In the impressive installation ceremony which closed the evening's entertainment the gavel of office was handed over to the incoming president, Dr. Margaret McGuire.

Wednesday morning at St. Joseph's Hospital, a workshop under the direction of Elizabeth Wright, R.R.L., Toronto Psychiatric Hospital, was a very interesting feature. A pleasant opportunity for the informal exchange

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W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Are you supporting your association?

ANYONE with experience in the hospital field is aware of how rapidly we have been undergoing change in the past few decades. Changes within the hospital have brought about alterations in design and transformations in administrative procedures. Sometimes these modifications occur so rapidly that it is difficult for administrators to keep pace with the current situation.

There may have been a time when it did not matter greatly if each administrator lived largely unto himself. Perhaps in those days each hospital could solve staff shortages, budget deficits and other managerial problems purely by ingenuity at a local level. If this was ever possible there is ample evidence today that the era has passed.

If hospitals are to achieve a maximum benefit for their patients it is essential that they work together. A realization that this was necessary was the driving force which created the provincial and regional hospital associations which we have in Canada today. It was people of vision who pioneered these organizations and nurtured them through their early years. Because of inadequate financing, their scope was at first limited. Yet because of what they were able to accomplish even on small budgets their strength has grown continually through the years.

The immediate future calls for stronger hospital associations than ever before. To an increasing degree, provincial governments are becoming more involved with general hospitals. Several provincial governments now sponsor hospital insurance programs and others have signified that they will embark upon such programs in the next year or two. Because of the inflationary increase in the cost of hospital care, individual hospitals and their provincial governments have found it necessary to integrate more closely their relationships regarding the economics of hospital patient care. In the foreseeable future hospital operation may be regulated to an increasing degree by governmental directives and, if these are to be effective and realistic, governments must be guided by a strong, united voice speaking for the hospital field. That voice will be heeded only if hospitals speak as a united group.

Let us not suppose that as individual hospital people we can go to our provincial governments, holding diversified views, and expect the governments to make sense out of a babble of voices. There is only one way we can expect governments to listen to hospitals and that is through the voice of their associations at the provincial level and their combined associations at the federal level.

Any organization is no better than the people who make up its membership. The way to improve your association is to become an active participant, giving it the benefit of constructive criticism and wise counsel. Each association needs the support of all hospitals and each individual hospital will need more and more the support of its association.

Goals in hospital administration

IT HAS been said that good administration requires a purpose that is clearly stated, well understood, and worthy of one's life blood. As the primary function of a hospital is complete care of the sick and the promotion of positive health, administration derives its goals from this central purpose. In other words, its separate goals are simply means for attaining good patient care.

Before anything really worthwhile can be achieved by such an intricate organization as a hospital, there must be effective co-ordination of all divisions within the institution, so that the whole functions as a complete unit. Hence major goals of hospital administration are good organization, adequate delegation of authority, and careful scrutiny of results. The administrator, as a co-ordinator, has to relieve tensions, promote security, and resolve problems. The administrator must have a strong sense of responsibility, the ability to lead, and full regard for the contribution being made by each staff member. As chief executive officer of the hospital, acting in liaison with the medical staff and fostering harmony

and co-operation between various groups, the administrator, more than anyone else, determines the atmosphere of the hospital. The administrator does not provide medical care but he can create a healthy climate in which medical care can grow. To ensure the best patient care, one of his tasks is continual planning in order to provide an adequate physical plant and satisfactory equipment. To ensure adequate financing, it is his duty to educate the community in what his hospital is trying to do, and to foster good public relations.

Hospital administration is a challenging vocation and many and varied qualities contribute to success. However, such attributes as compassion, ability to lead, foresight, adaptability, and humility will help the administrator attain the goals through which his hospital will accomplish in greater measure the primary objective for which it was established.

The Task of Revising CHAM

THE Committee on Accounting and Statistics of the Canadian Hospital Association met in Toronto during the latter part of August. Representatives were present from nearly all provinces and from the federal government. During their three-day meeting, draft material for the second edition of the *Canadian Hospital Accounting Manual* was critically examined. The work of revising CHAM has been a formidable task. During the early part of 1957, the association was fortunate in securing the services of George Steeves of Moncton, N.B., for a period of two months. His work has assisted substantially in the compilation of material for the forthcoming edition.

It is our wish that when the second edition of CHAM is published, it will not quickly become outdated. When the provinces enter into agreements with the Government of Canada for sharing the cost of hospital care, it is believed that certain additional statistical information may be required from hospitals. Some of these needs have now become known through Bill 320, and through discussions which have been held at federal and provincial levels. Nevertheless, it is believed that when final details are worked out there will arise circumstances which cannot be fully anticipated. For this reason the Committee have decided to delay the actual publication of the second edition of CHAM until 1958, or at least until such time as the full requirements of the federal-provincial agreements for hospital insurance are set down.

As the basic revision has been done already, it is considered that portions of the new edition should be made available to hospitals now. The amendments which have been developed have come about through experience gained in the use of the first edition, through improvements in standards of book-keeping and accounting done in hospitals, and through the need for more diversified information. As for much of this material, there is no reason to delay distribution. Accordingly, it has been decided to issue an interim publication which will contain certain essential sections of the proposed contents of the second edition of CHAM. These include chapters on charts of accounts, account descriptions, and the check list of supplies and services. This interim edition is in preparation now and should be available for distribution this fall.

Walter W. B. Dick has accepted a further term as Chairman of the Accounting and Statistics Committee and the membership continues with few changes. Walter Dick and his committee have contributed much time and effort to the work of this important aspect of hospital organization. Their industry and determination in striving to produce an improved manual, as well as their foresight and constructive thought in the field of hospital finance generally, stands as an inspiration for all.

Traduction

Le Comité de Comptabilité et de Statistique de l'Association des Hôpitaux du Canada a tenu réunion à Toronto dans la dernière quinzaine d'août. Presque toutes les provinces et le gouvernement fédéral y étaient représentés. Au cours des trois jours de réunion, les textes en préparation pour la seconde édition du manuel de comptabilité des Hôpitaux du Canada ont subi un examen critique. La révision du CHAM a constitué une tâche énorme. Au début de 1957, l'association a eu la chance de se procurer les services de Georges Steeves de Moncton, N.B., pour deux mois. Son travail nous a matériellement aidé à compiler les matériaux nécessaires pour l'édition à paraître.

Nous voulons que la seconde édition du CHAM ne devienne pas périmée peu après sa publication. Lorsqu'il y aura des ententes entre les provinces et le Gouvernement Fédéral du Canada sur le partage des frais d'hospitalisation, certains renseignements statistiques supplémentaires seront peut-être demandés aux hôpitaux. Quelques-uns de ces besoins sont maintenant connus grâce à la Loi 320, et par les discussions qui ont eu lieu aux niveaux fédéral et provinciaux. Cependant, on pense qu'au moment d'arrêter les détails définitifs, il se présentera des cas impossibles à prévoir complètement. Pour cette raison le Comité a décidé de remettre la publication définitive de la seconde édition du CHAM à 1958, ou au moins jusqu'à ce que toutes les exigences créées par les ententes fédéro-provinciales sur l'assurance hospitalisation soient connues.

Comme la révision de base a déjà été faite, on estime que des parties de la nouvelle édition doivent être fournies aux hôpitaux dès maintenant. Les modifications apportées sont le résultat de l'expérience acquise par l'usage de la première édition, de l'amélioration des standards de tenue des livres et de la comptabilité dans les hôpitaux, et du besoin de renseignements plus variés. Pour la plus grande partie de ce travail, il n'y a pas de raison d'en retarder la distribution. En conséquence, il a été décidé de sortir une publication provisoire qui contiendra certaines sections essentielles du contenu proposé pour la seconde édition du CHAM. Ces dernières comprennent des chapitres sur les nomenclatures de comptes, les descriptions des comptes, et la liste de classification des fournitures et services. Cette édition provisoire est actuellement en préparation et devrait être prête pour la distribution cet automne.

M. Walter W. B. Dick a accepté que son mandat de Président du Comité de Comptabilité et de Statistique soit renouvelé et la composition du Comité reste à peu près la même. M. Walter Dick et son comité ont consacré beaucoup de temps et d'éfforts à travailler sur cet important aspect de l'organisation hospitalière. Leur zèle et leur détermination d'arriver à produire un manuel amélioré, tout comme leur prévoyance et leurs idées constructives en matière de finances hospitalières en général, est un exemple propre à inspirer chacun.

SHARING SPECIALIST PERSONNEL

among smaller hospitals

D. F. W. Porter, M.D.,
Hospital Consultant,
Bathurst, N.B.

PATIENTS in small hospitals are entitled to standards of professional care at least equal to those of larger institutions. If these standards are provided, then the lot of those patients can be particularly happy as attention and care can readily be provided on a truly *personal* basis.

I would emphasize that the various phases of hospital administration (and some of the professional aspects) can ideally be provided to small hospitals by larger institutions under a properly conceived and executed system of integration. Several such systems are in operation on this continent and all of them have many practical lessons from which we might benefit. I shall discuss briefly four different systems of this type.

To the best of my knowledge, the concept of providing improved hospital care through an integrated system was first introduced on this continent, to a practical degree, in certain sections of central and south central United States. It was a truly co-operative effort in planning and operation, and therefore was highly successful. Funds for planning and, in some instances, for construction and initial administration were provided by foundation monies of the Commonwealth Fund; the actual planners were consultant specialists employed by the Fund and by State Departments of Health; monies for construction and equipment from government funds were diverted on a priority basis to hospitals participating in these schemes. The larger or "parent" hospitals provided a wide variety of personnel, advice, supervision, and training programs, while the smaller hospitals *asked for* advice and supervision and sent staff members to the larger units for these training courses. Even the boards of trustees of the hospitals shared in this pattern of providing hospital care. The continued success of the scheme was due to the vision and co-operation of key administrative staff.

Probably one of the most dramatic efforts in our time towards an integrated hospital system has just been partially implemented in the U.S.A. The Miners' Memorial Hospital Association has completed construction of some ten new hospitals with monies provided from the welfare funds of the parent union. I have been told that over $20,000,000 has already been spent on this project to provide hospitals where they are needed and wanted by those who are going to use them. The sharing of specialist professional and engineering staff, and the planning of each unit to fit into a particular place in the program is something to stimulate the admiration of all students of the plan.

Dr. D. F. W. Porter

Certain of our Canadian provinces have done some serious planning for an over-all integrated provincial hospital system. In New Brunswick, as far back as 1947, the Department of Health sought advice from and held many discussions with the New Brunswick Section of the Maritime Hospital Association in an attempt to develop an integrated hospital system. The joint planning was developed to the point whereby monies from certain of the health grants were directed on a priority basis to hospitals which were earmarked in the planning as "base" hospitals and to others earmarked as "regional" hospitals. In addition, various divisions in the Department of Health were gradually organized to make available to large and small hospitals advice and staff for the improvement of administrative and professional practices. One of the main reasons why this co-operative effort was not developed further was the fact that our New Brunswick hospitals failed to provide advice to the senior Department of Health officials when requested to do so. Many of the small hospitals of New Brunswick have greatly benefited by the sharing of specialists provided by the government under this particular program.

I now pass on to a fourth example of an integrated system located in eastern Canada which is now in operation. I refer to the group or system of hospitals owned and operated by the order of Sisters to whom I act as general hospital consultant. The various types of hospitals include active treatment, chronic and tuberculosis sanatoria, with a leprosarium in New Brunswick and one in Peru. All existing ones have been located on the basis of "need" and all of the

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From a paper presented to the Maritime Hospital Association Institute in November, 1956.

Two Briefs Submitted by the
Canadian Hospital Association to the

DEPARTMENT OF NATIONAL HEA

1. National Hospital Insurance

(With particular reference to depreciation and interest on capital loans)

IT is the belief of the organizations which constitute the Canadian Hospital Association that the voluntary hospital system, as it exists in Canada, is based on a concept which is essential to our way of life and must be preserved. It is our belief, also, that the government of Canada have a sincere respect for the voluntary nature of this hospital system and wish to maintain it under whatever plan the government accepts as the basis for contributing to the cost of hospital care from public funds.

Religious orders and voluntary boards of trustees have accepted for many years the responsibility of providing adequate hospital care and conducting the business affairs of their hospitals. We believe that they should be allowed to continue exercising the same functions in the future. The current plan of the federal government to contribute to the cost of hospital care, in conjunction with provincial governments, threatens this freedom because of the refusal of the federal government to include depreciation charges and interest on capital debt as part of the formula for their contribution to the cost of hospital care.

The Board of Directors of the Canadian Hospital Association, representing 17 hospital associations and Catholic Hospital Conferences, urgently requests the Government of Canada to reconsider the basis of the proposed formula for allowable expense in hospital services and to include depreciation on buildings and fixed equipment, as well as interest charges on capital loans. A hospital which has no provision for replacement of its fixed assets is in the position of having to seek funds for rebuilding and re-equipping its plant from whatever sources they may be obtained. It is, thereby, prevented from operating in a businesslike manner. We submit that this is not only unnecessary but unsound.

The financial investment which is now required for building and equipping a new or remodelled hospital is staggering to any board of trustees. At the present time government grants-in-aid pay approximately one-sixth of the total cost of such a program. The public is expected to contribute to the remainder, through actual donations and through higher per diem charges to meet interest on borrowed money. It is reasonable to assume that the public will not continue to contribute so freely in the future to an enterprise which they believe to be self-supporting — based on a reimbursement principle under National Hospital Insurance. In addition, the large sums which were at one time donated by philanthropists can no longer be depended upon for major projects.

Buildings and equipment are required to operate a hospital; and they must be renewed or replaced from time to time. Depreciation must be considered in order to create an accurate determination of the unit cost of service regardless of who pays the bill. Those who ignore depreciation are not administering their hospital in an orderly and realistic fashion. They are ignoring long-range planning so essential to sound administration. The *Canadian Hospital Accounting Manual* which was developed and approved by representatives of federal government departments, the provincial governments, and hospital associations, states:

"Depreciation of hospital buildings and equipment should be recognized as an element of hospital expense. The depreciation and value of buildings and equipment represents a real cost of hospital service, even though such assets may originally have been donated to the hospital . . . "

The principle of depreciation was accepted by representatives of federal government departments in 1951. WHY NOT NOW? To deny hospitals the right to operate in a businesslike manner will in the long run cause destruction of their financial independence and their existence as voluntary hospitals.

For the federal government to state that a provincial government

The first of the two briefs published here, that referring to depreciation and interest on capital loans in connection with national hospital insurance, was submitted to the Hon. Paul Martin, then Minister of National Health and Welfare, in February of this year. The second brief, pertaining to hospital construction grants, was submitted to the Hon. J. Waldo Monteith, now Minister of National Health and Welfare, in September.

may provide for the recovery of the cost of depreciation and interest on capital debts under their provincial plan is not sufficient if, so far as the federal government is concerned, the program is on a non-reimbursable formula. We believe that depreciation on buildings and fixed equipment and the interest on capital loans are a legitimate part of the operating cost of a hospital and should be so recognized in any *national* hospital insurance plan.

As we understand the present formula, should a province decide to cover these costs out of provincial funds, the hospital in that particular province will have no difficulty in undertaking future construction and/or paying off capital debts. However, where a province decides to take the same attitude as the federal government on this question, hospitals must find funds for this from other sources or close their doors when their physical assets become obsolete or if they are unable to meet their financial obligation on contracted capital debts.

What are these other sources of funds which are able to replace the customary method of making allowances for these costs in rates? The hospital can have a public drive for funds. After national insurance has been introduced the success of such public appeals will depend largely on the attitude taken by large corporations. Realizing that they are already contributing heavily to the plan by corporate taxes, they may refuse to make further commitments or such commitments as they make may be down-graded from past contributions under our present voluntary system.

It is our belief that after na-

(concluded on page 126)

2. Hospital Construction Grants

AS the federation of provincial hospital associations and Catholic hospital conferences, the Canadian Hospital Association represents the public hospitals of Canada. On their behalf we respectfully request:

1. That the hospital construction grants be continued for a further period of five years from April 1st, 1958.

2. That the scope of the grants be broadened in order that a construction project involving any hospital department or hospital residence accommodation may become eligible for grant assistance.

3. That the formulae upon which the grants are calculated be modified and the amounts provided be increased so that the contribution by the Government of Canada to each hospital construction project shall equal approximately one-third of the total cost.

This submission arises from resolutions unanimously adopted by our member associations and Catholic conferences at the meeting of the Association held in Saskatoon, Saskatchewan, in May, 1957. We hereinafter respectfully present a summary of our views concerning these recommendations.

Continuance of Grants

The federal hospital construction grants, together with the equal or greater matching grants from provincial governments, greatly stimulated hospital construction in Canada. The serious deficiency between the number of beds required and the number available, particularly in the public general hospitals providing acute care, has been sharply reduced during the nine-year period in which the program has been in operation. This improvement has come about in spite of the substantial increase in the total requirement for hospital beds of all types due to the increase of Canada's population.

There is still a shortage of hospital beds even by minimal standards, particularly in certain provinces. Considering the present ratios of need to availability and the obsolescence of many facilities still in use, and having in mind an approximate annual increase of 500,000 in the population, new beds for both acute and chronic care will continue to be required in the foreseeable future.

Subsequent to the meeting of our association and the adoption of its resolution in this connection, an announcement was made by the Government of Canada that hospital construction grants would be continued. Our association welcomed this announcement and believes that all circumstances warrant the continuation and expansion of this program.

Inclusion of all Departments and Services

With certain relatively minor exceptions (such as a combined hospital and public health laboratory) the hospital construction grant is conditional upon the provision of additional beds. When an entirely new building is to be constructed, or when additions and alterations materially affect the bed capacity of the hospital or residence, this limitation is not too

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Text of commemorative plaque in box below.

G. R. Baker Memorial Hospital

William C. Speare,
Administrator,
G. R. Baker Memorial Hospital,
Quesnel, B.C.

THE vigorous land of gold rush days and pioneer settlement in central British Columbia, known as the "Cariboo", is today the scene of phenomenal population growth and industrial development. Problems attributable to influx and expansion are encountered in every aspect of community life. Schools, roads, housing, water and power supply, all feel the solid impact of mounting community needs, while the small hospitals of this northern region strive valiantly to provide greatly increased and more varied patient care, with largely outmoded facilities. Provincial government and local district authorities alike have moved to initiate legislation and programs designed to introduce better standards and services where permanent need is established. The extent of this effort can be judged by plans now under way. New hospitals are in either the blueprint or construction stage in the centres of Williams Lake, Prince George, Pouce Coupe, Dawson Creek, Fort St. John and McBride. One in this region to achieve recent completion is the new 50-bed general hospital at Quesnel, B.C. Its story undoubtedly has points of value for others in similar circumstances.

THY HANDS DID HEAL

This work is in tribute to Dr. Gerald Rumsey Baker, 1873-1953.

In reverent respect to the pioneer doctor of this Cariboo District who devoted his life and services, under arduous frontier conditions, to meeting the medical needs of our early settlers.

Dr. Baker was known to all for his warmth of spirit, lively human interest and professional skill. His example serves as a constant ideal to all who are associated with the work of his calling.

This mural, sponsored by the North Cariboo Women's Institutes, was achieved by donations as personal tribute from his many friends of the Cariboo.

At the time of its inception in 1951, the G. R. Baker Memorial Hospital, named in tribute to the district's outstanding pioneer physician*, represented a tremendous project for so small an interior town, both in winning government approval for so extensive an institution to be built, and in co-ordinating all working interests to a final successful objective. In this it is a remarkable example of co-ordinated community effort, steadfastly pursued through set-backs and delays. At the close of its first year of operation the scope of planning and vision which has been devoted to this project becomes evident.

At the annual meeting held in March 1951, a report on the deplorable conditions at the then existing hospital was presented to the public. Attention was drawn to new provincial legislation providing for the establishing of Hospital Improvement Districts to assist in raising the communities' share of construction and equipment costs. An organizing com-

*See also page 112.

mittee was formed to investigate this legislation, and the proper procedure was followed for establishing such a district.

Work on actual planning of the hospital to meet the needs of this area — lumbering, ranching, and mining — was begun during the period of organizing the Hospital Improvement District. The architectural firm of Gardiner, Thornton, Gathe & Associates of Vancouver, B.C., commissioned for the project, developed an efficient layout to include an initial 50-bed hospital, and nurses' residence designed for 18 occupants. All facilities of the hospital were based upon an eventual 100-bed capacity. The floor plans illustrated here indicate clearly the design of this small hospital.

The hospital staff, architects and government departments entered into a prolonged period of correspondence over proposals and rejections. Detailed patient statistics and service studies were completed for each department. Separate services were investigated to determine which were feasible and financially possible. Bed allotments, paediatric and maternity percentages, patient routing, departmental traffic, staffing, operational costs, latest advances in the hospital field—all these were the subject of review and correspondence with the architect and other authoritative sources. Equipment acceptable on the basis of capacity, design, and cost, was selected for each area—surgery, maternity, x-ray, laboratory, kitchen, laundry, wards and public areas. All proposals and plans were submitted to the Hospital Construction Department of the British Columbia Hospital Insurance Service and revised many times before final acceptance. For each separate piece of equipment three quotations were obtained, as an essential requirement in dealing with the government grants and public funds. Initial construction costs were necessarily higher than average because all facilities were provided for additional beds. At the present consistent rate of population increase this planning has proved to be well-founded.

Nurses' station on main floor ward.

The general building construction is poured reinforced concrete. Room partitions are plaster on hollow tile with ceilings of random punch acoustic tile. Floors are of terrazzo with moulded base of rubber composition. Service area walls are finished in ceramic tile. All windows are of a self-contained metal sash type with combination storm sash and screen for easily maintained year-round use. Fire escapes are situated at

The front of the hospital from the roadway.

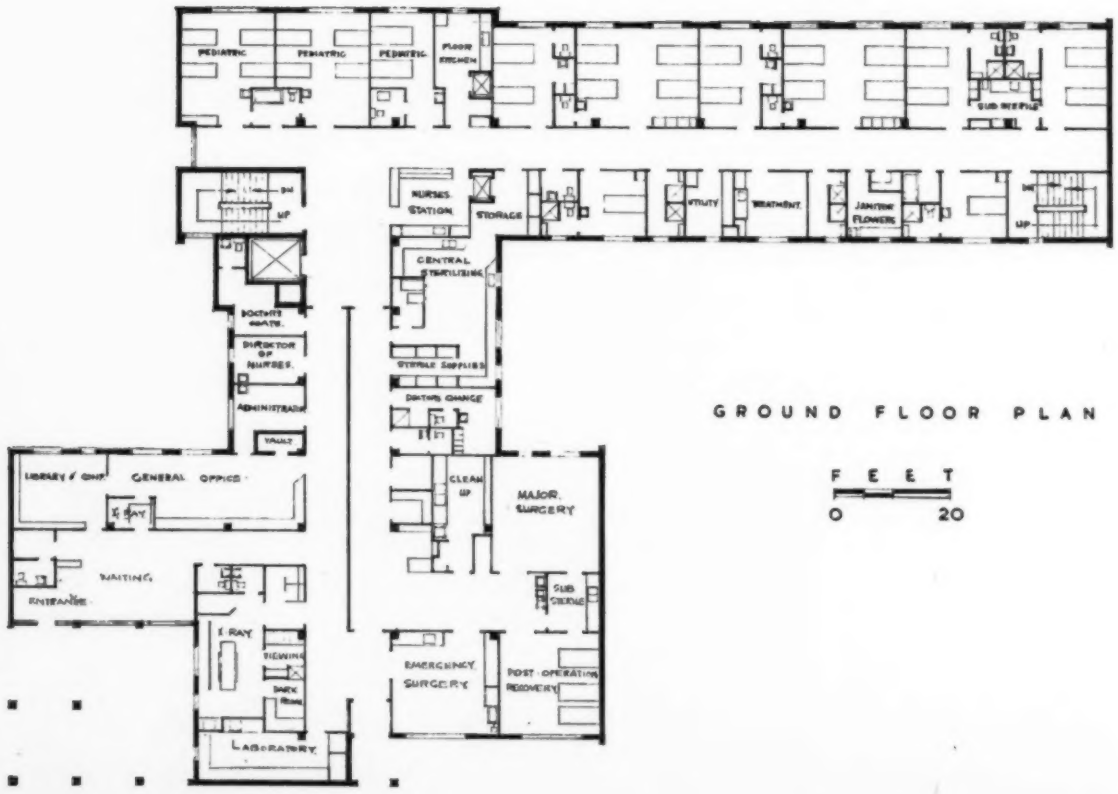
Major operating room.

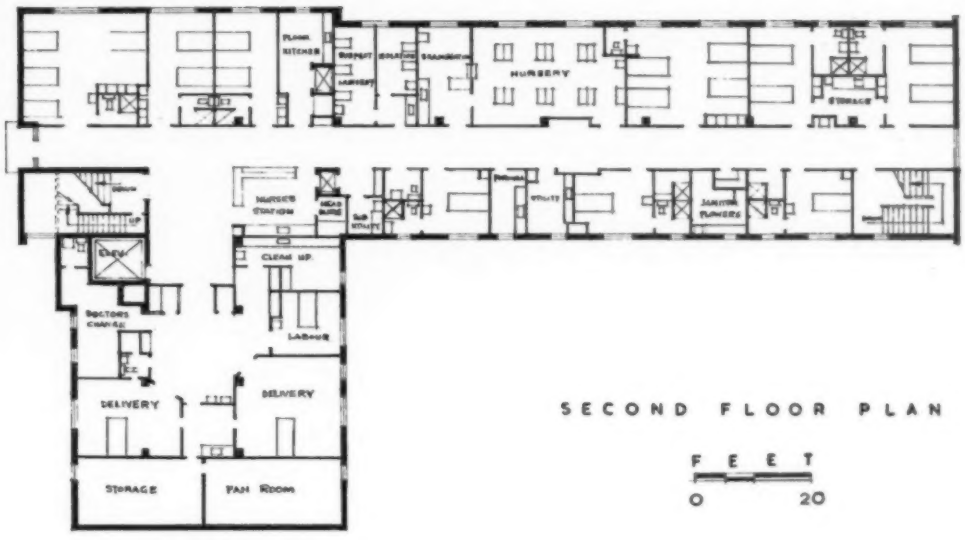
Architects:
Gardiner, Thornton, Gathe & Associates,
Vancouver, B.C.

either end of the corridor with midway asbestos baffle doors. The building also houses an automatically controlled passenger elevator and two dumb-waiters for linen and dietary service.

Laundry, kitchen, morgue, and boiler room, as well as bulk storage areas, are situated in the basement. The oxygen manifold room in this same area, separately enclosed to prevent explosion hazard, provides piped oxygen throughout the building. The modern plant provides steam for sterilizing, autoclaving, and laundering during the eight-hour day shift with the work schedules of these departments planned accordingly. The whole hospital operation is designed to switch over to electrical equipment for cooking or any simple or emergency sterilizing, et cetera, for the evening and night shifts, thereby permitting a considerable yearly saving in steam engineer staff payroll. An automatic standby 25 KV diesel auxiliary power plant is also located in the boiler room area.

The ground floor contains the admitting and general administration offices, x-ray and laboratory departments, surgery, as well as




NURSERY
STORAGE
NURSES STATION
CLEAN UP
LABOUR
DELIVERY
DELIVERY
STORAGE
FAN ROOM
SECOND FLOOR PLAN
F E E T
0 20


STORAGE
STAFF DINING
DISHWASHING
COOKS OFFICE
DRY STORE
DAIRY REFRIG
BULK FOOD STOR
MEAT REFRIG
PHARMACY STORAGE
KITCHEN
JANITOR
UP
DIRTY LINEN
SPUN STAFF
HOUSE-KEEPING
FEMALE HELP
LAUNDRY
NURSES' LOCKERS
VEGETABLES
GARBAGE
RECEIVING
UNEXCAVATED
BOILER ROOM
MALE HELP
MORGUE
OXYGEN MANIFOLD
INFLAMMABLE STOR.
WORK SHOP
SWITCH ROOM
TRANSFORMER
BASEMENT FLOOR PLAN
F E E T
0 20

Rear view of the hospital.

medical surgical and paediatric wards. Sufficient information on the growth and activity of the district was compiled to warrant the installation of a chest x-ray unit adjacent to the admitting office. The emergency entrance provides level access with the hospital driveway and permits ready access to the emergency operating room, planned in close relation to the x-ray, laboratory, blood bank, and major surgery. There are two major operating rooms, one of which at present is used for post-surgical recovery. The patient's bed may be wheeled to the post-surgical recovery room, and when the patient recovers in his own bed, it is transferred back to the ward, thereby eliminating undue movement. Surgical and delivery room areas are explosion-proof with wall-recessed x-ray film illuminators, temperature humidity controls, and air conditioning. The second floor provides accommodation for 12 maternity beds and eight additional beds which may either be used for maternity or post-surgical cases. The nursery, equipped with piped oxygen and suction, accommodates 12 individual bassinet units, in addition to a small suspect nursery and a two-unit premature nursery. The maternity suite based on a wheel design includes two delivery rooms, doctors' sleeping lounge, labour room, sub-sterile area and various rooms for anaesthetic, linen storage and blanket warming.

Above: the staff dining room with pass-through to kitchen. Below: view of kitchen provided with equipment sufficient for expansion.

Patient accommodation includes four-bed standard wards numbering 24 beds, 18 semi-private beds and five private wards. All beds are fully adjustable, with the room furnishings varied, yet interchangeable, and in many colours. Each room has an individual toilet, shower, and wash basin. All beds are screened with fire-proof spun-glass cubicle drapes mounted on a noiseless ceiling-suspended track. Dynamic colour theory was fully applied throughout the wards and service areas. Colours were chosen and related for the needs of specific areas. They successfully create the desired effect whether it be to stimulate and cheer, or soothe and comfort.

There are three separate intercommunication systems in the hospital; one a direct inter-telephone system to each department; the second, a patient bell signal system of advanced design; and a

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You and Your Publics

John Hornal*,
Toronto, Ont.

ONE way of defining public relations is to say that it covers our relations with various publics. In business it refers to our relations with clients, employees, shareholders, and the community at large, including governments. In hospitals it refers to our relations with patients, patients' friends and visitors, doctors, employees, and the community. The art, science or profession is that of establishing good relations with these publics and preventing bad relations from developing. The aim of public relations is distinct from the aim of selling. According to Kenneth Cross of the Ontario Hospital Association, the aim of public relations is to inform, inspire, and to show consideration. One object is to achieve that degree of public acceptance or understanding necessary to avoid needless friction. As Lincoln said, "Public sentiment is everything, with it nothing can fail, without it nothing can succeed". Leonard L. Knott, the author of *The P.R. in Profit*, says that good deeds or intentions are the raw materials of good public relations; making these known to the public constitutes the process of manufacturing good public relations.

I approach this subject with a sense of inadequacy because for many years I viewed the term "public relations" with suspicion. I looked upon public relations men as being simply press agents. I believed that in hospital work if we performed our tasks efficiently and with good will that this was the best form of public relations. I felt that we came in contact with such a large portion of the community that the public would recognize the spirit of our work and that anything we would say about it would be a superfluous effort. I have come recently, however, to an entirely different attitude and now realize that something more than the performance of good deeds with good intentions is needed. I have come to realize that it is not sufficient to have merely good intentions but that it is necessary to communicate this spirit effectively to our publics. After all, it matters little how good the preacher's message is if you cannot hear it or if it is phrased in a language that you cannot understand. If we are doing a good work and we thoroughly believe in it, we should do everything possible to make it effective, and it cannot be effective unless people accept it in the spirit in which it is conceived.

How Shall We Do This?

Public relations is a career for many people and these professionals will tell you that they can do a much better job than any amateur. This is probably true; but while we appreciate that professionals can look at a problem much more objectively and that amateurs can misjudge public reactions horribly, we are faced with the fact that in many of our hospitals revenues do not permit even relatively small expenditures for professional advice.

Hospitals in Ontario have the services of the Public Relations Committee of the Ontario Hospital Association and the members of its public relations staff, including its enthusiastic director, Kenneth Cross, who are always ready to help in any public relations program. The association from time to time develops news releases which reflect the hospital position generally. Mats are provided for advertising, trailers are provided for movies, films are provided for television. Booklets are developed explaining the hospital viewpoint which are suitable for general distribution.

These helps provided by the association are all very useful but something more dynamic is required, something that appeals a little more closely to the people in your own community, a message that exudes the warmth of your own personality.

Strangely enough, the person with whom we have the least trouble generally is the patient, especially if he or she is quite sick. The patient approaches us with fear and with hope, is in a dependent frame of mind, and accepts gratefully the administrations of the hospital. Since most of our effort is directed to the care of the patient, a fair degree of communication is developed. We should do our best, however, to improve these communications, to make sure our regulations are simple and clearly defined, that the reasons for these are clearly understood. For example, if we limit visiting in the maternity department it should be explained that it is not because we do not like visitors, but because we wish to protect the health of the baby and the mother.

We must remember that while many people have visited hospitals and heard of hospital procedures, few have thought very much about the reasons for them. An explanation of exactly what is being done and, if possible, why, is very helpful in reassuring the patient. To the person on a bland diet it may be very distressing and upsetting if he is not told that this is part of the doctor's program for restoration to good health. The delay of breakfast until a "blood sugar" is taken may upset a patient if he is not told that the test would be useless if the fast were broken. Of course, in all these explanations there is danger of infringing on the doctor's territory. Many doctors are too busy to explain to their patients the purpose of every detail of their treatment and there arises a problem of how much the nurses, dietary staff, or technicians should explain. If the staff is relatively stable, an understanding will often develop between doctors and staff as to how much may be told to each doctor's patients by the staff. Other things being equal, a stable staff should therefore contribute to good public relations. The understanding patient will probably respond better to treatment. Sufficient nursing staff is essential so that each patient may be given the treatment he needs as an individual.

The patient's friends and visitors do not share the patient's feel-

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**Mr. Hornal is director of the Training Programs Branch, Ontario Hospital Services Commission. This article is from an address delivered before Regional Council No. 3, Ontario Hospital Association, Hanover, June, 1957.*

ing of dependency. These people are much more easily irritated by hospital regulations, by questions asked in the admitting department, by long waits for admissions, by bells unanswered if they should happen to be in the room. We must remember that these people are concerned about their friends, they desperately wish to help but find themselves unable to do so and they are critical when the hospital fails to give promptly the service they wish they could give. Probably no department of the hospital receives more criticism than the admitting department because of the long delays. From the viewpoint of public relations the best you can do for the patient's friends and visitors is: (1) show the utmost consideration for the patient; (2) explain where necessary the reasons for your regulations; and (3) apologize promptly and sincerely for any needless delay or inattention.

It is interesting to note here that a public relations program which portrays only the good points in your organization is apt to fail. That is one reason why public relations counsels argue that writing about an organization should be done by someone outside the organization. The person in the organization is inclined to tell only the good points while the objective reporter will note your weaknesses as well as your strength. The public will tend to disbelieve and lose interest in tales of perfection.

One of the most important publics you have is that of your employees. It is vitally important that they be happy in their work, that they believe they are partners in the work you are attempting to do. It is also important that your employees' families should be happy that a member of their family is working with you. In larger hospitals we might stress the value of a house organ as a means of informing employees of your policies and your aims. However, this is hardly practical in the case of small hospitals. Administrative conferences of different groups of employees can be arranged and policies explained and suggestions received. The administration can inaugurate an in-service training program which will make employees feel that they are improving themselves and will add to their interest in their work as well as making them realize more clearly what the aim of their work is. In this connection I hope the Ontario Hospital Services Commission may consider establishing institutes to help administrators with programs of in-service training. Various departments can put on demonstrations to inform other departments about their work. On occasions it may be necessary to ask your employees to make an extra effort to meet a serious situation. The important point to remember, when this is necessary, is not only to outline to employees the reason for this request but to tell them, too, what you are doing to meet the situation. This gives them a sense of team-work.

Doctors are another special public. While they will have been consulted about many of your basic policies it is sometimes difficult for them to understand the reasons for many of your administrative policies. It is wise therefore to pass to your Medical Advisory Committee, either for information or approval, as many as possible of your administrative policies affecting patients, before putting these into effect. In the strict sense it may be none of their business and if it is not they will recognize this. On the other hand because they know patients they may be able to give you worthwhile suggestions. In any case it is well to have them understand your policy and the reasons for it because it is to the doctor that the patient and his immediate relatives go if they do not understand hospital policies.

John Hornal

Another special public of the hospital is the board of trustees. These correspond to the shareholders in a commercial organization. I imagine that in most hospitals board members take quite an active interest in the actual functioning of the hospital. It is possible, however, that there may be some members of your hospital board who only read financial statements and listen to committee reports, who do not know your staff or what their function is in your hospital. This, administratively, may be good as their function is to analyze situations and lay down policy; but, public-relations-wise, it does not give them understanding of the organization they are trying to direct. Special sessions aimed to demonstrate various activities of the hospital are valuable for members of the board.

A very special public which will help you in your relations with all your other publics is your women's auxiliary. These devoted women have formed themselves into an organization because they believe you are doing a good job for their community, and because they wish to help you do a better one. They not only contribute services to your hospital, often exhibiting a personal interest in the needs of the patient by operating tuck carts, or shops, operating a library service, providing tray favours on festive occasions, but they raise money to improve your service. Because they do these things, they become informed about your hospital and endeavour to have you regarded favourably in the community so that their money-raising efforts will be successful. They can be a source of very constructive criticism, they can act as a poll of public opinion, and they can do marvels in interpreting the hospital to the community. It is a wise administration that listens to what they have to say and takes the trouble to keep them as fully informed as possible. It is often possible at their meetings to have a short talk or demonstration given by a member of the hospital staff or to have a board member explain some features of board policy.

Last, but not least as a public, is the community at large. This public is interested in you from at least three viewpoints:

1. That you are ready to provide efficiently and economically a service which their families or their employees may need in the future.

2. That the hospital reflects credit on the community.

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— a symposium —

Provision of Diagnostic Services

1. a pathologist speaks . . .

H. G. Pritzker, M.D.,
Director of Laboratories, New Mount Sinai Hospital, Toronto.

IT might be wise, at the outset of this paper, to state that the word "pathology" will be used synonymously with clinical pathology, to include all branches of laboratory medicine, such as morbid anatomy, bacteriology, biochemistry, haematology, serology, blood banking, et cetera. Furthermore, it should be pointed out that as far as pathology is concerned, the present status of medical science requires laboratory aids for the prevention and treatment of disease as well as for diagnosis.

Years ago most hospitals had a very small laboratory or none at all. The few pathologists available at that time were mostly teachers of pathology in university centres and did not practice laboratory medicine as it is known today. Parenthetically it can be stated that a so-called private practice of pathology in an independent office laboratory, comparable to practice by other specialists, became exceedingly difficult in most parts of Canada because of the services offered by provincial public health laboratories, at little or no cost to the physician and patient using these services.

Hospitals, in order to keep pace with the advances in medical science and upon the advice and urging of their medical staffs, have greatly increased the size and scope of their laboratories. In most hospitals this change has been brought about wisely and in consultation with the hospital pathologist.

Over a period of years, demand has increased for clinical and pathological services and, along with this, there have been pyramiding costs of hospitalization. In an attempt to secure additional revenues hospitals naturally began to look to these expanding clinical pathological services as fruitful sources. Thus many hospitals have, more or less, gradually moved into the field of medical services for which they charge medical fees or the equivalent. This policy tends to establish a dangerous and invidious precedent. It transfers the ultimate responsibility for medical service to what is primarily a lay organization. It is possible to foresee that when particularly hard-pressed for revenue, a hospital or institution might desire to make the clinical pathological laboratory a paying rather than a progressive department. This would eventually result in deterioration of the calibre of the medical personnel involved. The quality of the work performed would ultimately be reflected in inferior patient care.

H. G. Pritzker

Trends in recent years

Certain trends in laboratory medicine have become established. It has been found, for example, that some hospital laboratories established within the past five years have already outgrown their facilities. Figures show that in the past 15 years the volume and diversity of laboratory services performed per patient have more than doubled and the trend is that this increase will continue as the practice of medicine continues to develop and expand. These facts emphasize that the size, equipment and personnel of the clinical pathological laboratory should depend upon the number and complexity of the services performed rather than on the number of patients investigated. It also follows, therefore, that the income required by a clinical pathological laboratory must be correlated with the volume and type of service performed as well as the actual number of specimens submitted.

Fundamental principles

Because of the developments outlined above, the association between hospitals and pathologists has been close and, for the most part, amicable. However, those relationships have been rather ill-defined and certainly not uniform. Today, with the increasing participation of third parties, whether private or governmental, as carriers of costs of medical services, we pathologists feel that a clear-cut distinction should be

(Continued on page 80)

The three papers composing this symposium were presented at the 45th annual meeting of the Canadian Public Health Association, Toronto, Ont., May 27-29, 1957.

2. viewpoint of a radiologist . . .

D. C. MacNeill, M.D.,
Radiologist,
Welland County General Hospital,
Welland, Ontario.

IN Ontario, there has been established a very high quality of diagnostic accuracy in hospitals, clinics and private offices. Not a small share of the credit for this must go to the group I represent, namely, the Radiology Section of the Ontario Medical Association. Our group includes about 135 physicians, certified by the Royal College of Physicians and Surgeons of Canada in the field of diagnostic radiology. Other members of the profession are enrolled in the section because of their interest and experience in this field. It is our very firm belief that this section of the profession in Ontario must take strong leadership in the maintenance of the high standards of diagnosis afforded by our specialty. No compromise must be made under any scheme of health insurance coverage which might jeopardize those standards. I will refer to such possibilities later.

My personal feeling is that the continued provision of high quality diagnostic radiological services is the most important aspect of this topic. However, I will endeavour to show that the methods of payment for such services might well influence the quality, particularly where a large increase in demand for these services is to be expected.

Let us examine the various major sources where these services may now be obtained in Ontario. These are the public hospitals, the sanatoria for tuberculosis, mental hospitals, the private offices of certified radiologists, certain clinics having a certified radiologist on their staff and, finally, other clinics and doctors' offices.

The public general hospitals of Ontario provide the greatest number of total diagnostic examinations through their departments of radiology. Almost all of these departments are directed by a radiologist certified at least in diagnostic radiology by the College of Physicians and Surgeons of Canada. The hospitals of Ontario have recognized that the quality of service rendered in these departments depends primarily on maintaining this standard of direction, and that wherever feasible it should be full-time. Furthermore, the radiologist in charge must have reasonably complete autonomy as to his staff and equipment. The international Joint Commission on Accreditation of Hospitals insists on this type of direction and is also insistent on written and signed reports on every fluoroscopic and radiographic procedure conducted on a hospital patient, the original copy of which is permanently preserved on the patient's hospital record.

The continued provision of this type of hospital service depends on the continued enlistment of doctors training in the specialty of diagnostic radiology. If this specialty becomes less attractive to graduates in medicine, either through increased patient loads or reduction in recompense as compared to other medical specialties, the supply of trainees in radiology in Ontario will dwindle far below the figure necessary to meet the needs under any scheme of health insurance.

The departments of radiology in public general hospitals are at present examining large numbers of out-patients as well as in-patients. The proportion of each in my own hospital is approximately 50 per cent. Most of these departments are working at close to maximum capacity. Some departments are examining heavy patient loads under very adverse conditions. The Section of Radiology is of the opinion that an ever-increasing proportion of examinations in these departments will be in-patients. The ratio of total in-patient examinations to total number of patient-days in any one year will increase very significantly. Many patients in hospitals now would receive more extensive radiological work-up if they were covered by health insurance without upper limit.

D. C. MacNeill

What will be the result of this trend on the operation of departments of radiology? In-patients will be given priority to prevent lengthy hospital stays and the out-patient coverage must suffer. Elective examinations of out-patients will accumulate and long waiting periods for such studies will ensue. This is exactly what has happened in British Columbia. The B.C. hospital radiologists are desperately trying to keep pace with the demands but are not successful and many out-patients are being examined in the offices of private radiologists at their own expense rather than waiting weeks for a "free" examination in the hospital. Further, the hospitals of British Columbia have been unable to attract assistants to aid the too few hospital radiologists as the salary arrangement offered, necessitated by the plan's budget, is not attractive to radiologists from other parts of Canada. In fact, some hospital radiologists have left hospital practice to establish their own private offices where working conditions and budgets are under their own control and income levels higher. I am quite safe in saying that a similar exodus from hospitals in Ontario of a significant number of our section is inevitable if careful thought is not given to the problems to which I am referring.

Thus the paramount factor in the continued provision of high quality diagnostic radiology in the hospitals of this province is insurance of direction by radiologists without unrealistic controls by laymen, be they hospital administrators or civil servants. The Ontario Medical Association, through its Section of Radiology, is prepared to recommend machinery to control such factors as the number of radiologists servicing a department, the amount and type of equipment, the number of technical personnel and the use of supplies. Over-utilization of radiological services is a

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3. the attitude of hospitals . . .

G. Harvey Agnew,
M.D., LL.D., F.A.C.H.A.,
Professor of Hospital Administration,
School of Hygiene,
University of Toronto.

THE general subject of the relationship of radiologists and pathologists to hospitals is a complicated one which cannot be resolved quite as simply as some would seem to think. There are many factors involved and all have a bearing on the solution. These include the historical development of these departments and their traditional relationships, professional principles and ethics, financial considerations, the welfare of the public, and potentialities for the future in the light of current anticipated changes in the provision of medical and hospital care.

A satisfactory solution has been delayed by the unfortunate fervour with which certain viewpoints have been urged and the prevalence of heat rather than light in some of the discussions. All too often the interests of the patient would seem to have been overlooked.*

My colleagues will have stressed the contention that it is unethical for a physician to be employed by a hosiptal on a salary or even on a percentage basis. Reference will probably have been made to certain court decisions and statements of the Attorney-General in the United States that it is illegal for a hospital to "practice medicine", by which is meant to employ a physician and charge for his services. Both radiology and pathology are to be regarded as specialties with the same academic standing as other specialties. It is contended, too, that both pathology and radiology should be paid for on a fee-for-service basis and that all revenue accruing to the hospital should be applied to these services only. Fees should be paid for as medical and not as hospital services.

In recent years both departments have become highly remunerative —partly because of the greatly increased volume of work, and also due to an increase in third-party payments and increased charges. There has been a strong demand, particularly by certain spokesmen for the radiologists, that a "lease" arrangement be effected whereby the space would be leased from the hospital, and the radiologist would meet all expenses of operation and take the earnings. Further reference to these points of contention will be made shortly.

There are many points, fortunately, on which there would seem to be general agreement. The hospitals believe that the radiologist and the pathologist should be accorded the recognition which a qualified expert in a medical specialty should have and should rate on the staff as any other member. As highly qualified specialists, the pathologist and the radiologist should have an income commensurate with that background of qualification. The hospitals fully agree that standards must be kept high.

Hospitals generally would be quite willing to include the name of the pathologist and the radiologist on the account rendered.

The hospitals believe, and I understand that my colleagues on this panel share this view, that the ownership and maintenance of the laboratory and x-ray facilities, and the operation of these services are proper functions of a hospital. This viewpoint was subscribed to by both the medical and the hospital groups in the preparation of the new Iowa legislation. The new Act states:

Sec. 3. The ownership and maintenance of the laboratory and x-ray facilities and the operation of same under this Act are proper functions of a hospital.

There are certain proposals and statements with which the hospitals cannot agree. One of these is the "lease" basis of operation. These two departments are too fundamental to the welfare of the patient for a non-profit hospital to turn either of them over to private interests controlled in most instances by one individual. To do so would be to create a private monopoly of a vital clinical service which would then be operated for profit. Experience of some hospitals where this was done was very unsatisfactory, both as to quality and continuity of coverage and replacement of obsolete equipment. One is pleased to note that spokesmen for these two groups are not stressing this basis as they did a while ago.

Use of Hospital Income

The hospitals do not subscribe to the viewpoint that any net revenue coming to the hospital from one of these departments should be spent necessarily on these departments. Hospitals do keep them up-to-date and lavish much money on them—I see this everywhere—but it would be absurd to waste money on any department. Hospitals are not shoe factories; they cannot discontinue a line that does not pay. They operate clinics and public wards at a financial loss in the interests of the public. Being non-profit, no dividends go to individuals, so what net revenue is not needed for radiology or pathology, as the case may be, goes to finance public wards and/or clinics.

If this be wrong, then the logical alternative would be to lower the unit charges. Do the societies want that?

Hospitals strongly resent, also, the accusation that any salary or percentage basis constitutes "fee-splitting". When a hospital retains a portion of the net revenue, it is only receiving a fair return for the use of the expensive equipment bought by the hospital, the technical services paid for by it and the provision and maintenance of space also paid for by the hospital. In small hospitals the amount left for the hospital is often far

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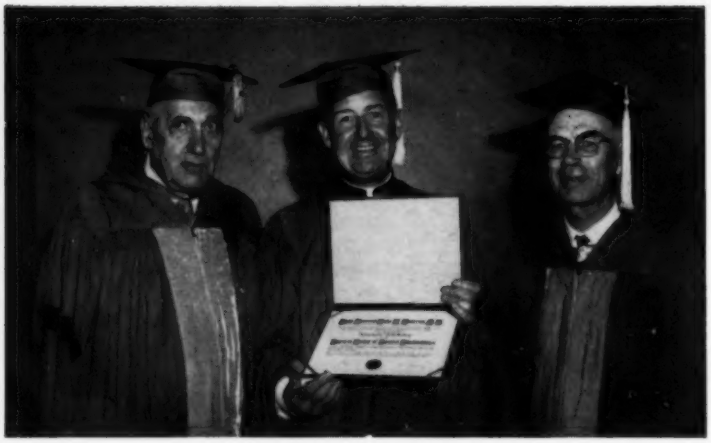
G. Harvey Agnew

**Here the author explained that having been asked to represent the viewpoint of hospitals he must accept sole responsibility for his interpretation of their position.*

Dr. Agnew is a hospital consultant with the firm, Agnew, Craig & Peckham, Toronto, Ont.



Rt. Rev. Msgr. J. G. Fullerton was awarded an honorary fellowship by A. J. Swanson (left). Dr. A. C. McGugan read the citation.

Annual Convocation of the A.C.H.A.

HONORARY fellowships for "outstanding contributions to the field of health" were conferred on four persons by the American College of Hospital Administrators at the convocation held in September at Atlantic City. At the same time, 97 members of the college were honoured with fellowships; 238 nominees were named members; and 340 persons were admitted to nomineeship.

Recipients of honorary fellowships were Rt. Rev. Msgr. John G. Fullerton, director of Catholic Charities for the Archdiocese of Toronto; Rear Admiral Lucius W. Johnson (Ret.), San Diego, California; Lucile Petry Leone, assistant surgeon general and chief nurse officer, Public Health Service, Department of Health, Education, and Welfare, Washington, D.C.; and Dr. William S. Middleton, chief medical officer of the Veterans Administration, Washington, D.C.

The College's annual banquet, held at the Traymore Hotel, was highlighted by the presentation of the president's emblem and the Arthur C. Bachmeyer Memorial Address. J. Dewey Lutes, ACHA president in 1956, was given the president's emblem by president A. J. Swanson of Toronto. The emblem is given in recognition of the service rendered by the recipient as president of the College.

This year the Bachmeyer Memorial Address was given by Elmore Petersen, dean emeritus of the School of Business at the University of Colorado. The subject of his address was "A Practical Philosophy of Administration".

Mr. Petersen opened his address by stating "efficiency in administration is not a question of science or philosophy . . . but it is rather a matter of recognizing the important application of both of these disciplines to the task of administration."

"The science of administration is analytical", he stated. "It deals with the techniques of organization and management. In contrast, the philosophy of administration is synthetical; it undertakes to combine the components of organization and management into a co-ordinated whole, and to define the principles and purposes that should govern administration.

"The practicality of such a philosophy", said Mr. Petersen, "is determined by three criteria: (1) the philosophy of administration must be consistent with the recognized principles of organization and management; (2) it must be of such a character that it is the dominating influence in shaping the policies and achieving the objectives of an enterprise; and (3) the philosophy of administration tends to

Fellows . . .

Sister M. Clarissa

Sister Gertrude Jarbeau

conform to the personal philosophy of the administrator."

In his address to the College, president Arthur J. Swanson, chairman of the Ontario Hospital Services Commission, announced that in commemoration of the College's 25th anniversary in February of next year the ACHA will hold a special three-day educational conference.

Succeeding Mr. Swanson as president of the College for 1957-58 is Frank S. Groner, administrator of the Baptist Memorial Hospital, Memphis, Tenn. Anthony W. Eckert, director of the Perth Amboy General Hospital in New Jersey is the new president-elect.

Albert G. Hahn of Evansville, Ind., was elected first vice-president of the College and Mr. A. A. Aita of Upland, Calif., second vice-president.

Canadians Honoured

Honorary fellowship was conferred upon Rt. Rev. Monsignor John G. Fullerton, director of Catholic Charities in Toronto, Toronto, Ont.

Advanced to Fellowship

Sister M. Clarissa, administrator, St. Rita Hospital, Sydney, N.S.

Sister Gertrude Jarbeau, administrator, St. Boniface Hospital, St. Boniface, Man.

Mother Jeanne-Mance, assistant administrator, University of Montreal Hospital, Montreal, P.Q.

L. F. Clifford Kirby, director, Royal Columbian Hospital, New Westminster, B.C.

Sidney Liswood, administrator, New Mount Sinai Hospital, Toronto, Ont.

Donald M. MacIntyre, Kitimat, B.C.

Mrs. Dora E. Shrimpton, assistant superintendent, Toronto Western Hospital, Toronto, Ont.

Advanced to Membership

Eugene F. Bourassa, business manager, Regina Grey Nuns' Hospital, Regina, Sask.

Henry S. Doyle, assistant superintendent medical, Toronto General Hospital, Toronto, Ont.

Lucien Lacoste, assistant director, Notre Dame Hospital, Montreal, P.Q.

John MacKay, administrator, Peterborough Civic Hospital, Peterborough, Ont.

Sam Ruth, administrator, Jewish Home for the Aged and Baycrest Hospital, Toronto, Ont.

Nominees

J. E. Bragg, administrator, North Vancouver General Hospital, North Vancouver, B.C.

Jackson R. Bryan, superintendent, Welland County General Hospital, Welland, Ont.

Sister Claire Gauthier, administrator, Holy Cross Hospital, Calgary, Alta.

Clifford F. Ellis, assistant administrator, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, P.Q.

Sister M. Helena, administrator, Mater Misericordiae Hospital, Rossland, B.C.

Robert F. Ingram, M.D., assistant director medical, Royal Victoria Hospital, Montreal, P.Q.

Sister M. Janet, superintendent, St. Michael's Hospital, Toronto, Ont.

Howard Kenneth Krafft, admin-

Dora E. Shrimpton

L. F. C. Kirby

Mother Jeanne-Mance

Sidney Liswood

Donald M. MacIntyre

New Members . . .

Eugene F. Bourassa

John MacKay

Henry S. Doyle, M.D.

Nominees . . .

Sam Ruth

Soeur Marie-Angèle

istrator, Peel Memorial Hospital, Brampton, Ont.

Soeur Marie-Angèle du St. Sacrement, administrator, St-Louis Marie de Montfort Hospital, Ottawa, Ont.

Sister Mary Mackenzie, superior, Hôtel-Dieu de St. Joseph, Chatham, N.B.

Sister Marie-du-Christ-Roi, director of nursing, Hôtel-Dieu St-Augustin, Montmagny, P.Q.

Sister Mary Grace, administrator, St. Joseph's Hospital, Hamilton, Ont.

Douglas Russell Peart, superintendent, Ottawa Civic Hospital, Ottawa, Ont.

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Lucien Lacoste

Sister Mary Grace

Sister Rose Marie Prieur

You Were Asking . . .

Several administrators of hospitals of various sizes across Canada were asked to answer the following question: *What does your hospital do in attempting to foster good community relationships?* The answers received are as follows.—*Edit.*

Turner Valley Municipal Hospital District No. 66, Turner Valley, Alberta.

THE rôle of the small hospital in a community presents a personal challenge. We attempt to foster good community relations through the service we give our patients—working on the premise that each satisfied patient remains a booster.

We deal with local tradesmen and try to recruit non-professional staff from the community.

We give every consideration to patients' visitors who cannot come during visiting hours. In the case of serious or terminal illness, we allow the family to remain in the hospital. They are given coffee and meals if necessary.

Our nursing and auxiliary staff take a personal interest in our patients' care.

We serve home-cooked style meals, allowing patients a choice, if they are on restricted diets.

We have a varied selection of reading material and a good library of donated books.

Our medical staff are always readily available for any emergency, assuring our patients that they will be well looked after while in hospital.

In general, all the above considerations, and the homey atmosphere established in a small hospital, help greatly in fostering good community relations.—*(Mrs.) Cora S. Burke, R.N., Matron.*

* * *

Sarnia General Hospital, Sarnia, Ontario.

WE use a number of methods which help to promote good community relationships, several of which are the generally accepted procedures which most hospitals utilize.

The value of women's auxiliaries has been proved. Our hospital has two, one of which has the specific project of the Children's Ward. It is natural for the members of these auxiliaries to boast truthfully of "their" hospital among their friends. This reaches a good segment of the community population.

By talking to civic and service organizations about hospital finances, problems, services, and future plans, administrators reach the community citizens who are influential—and who ask pertinent, thought-provoking questions. The press is usually present at such gatherings.

We also use the technique of having regular conducted tours of the hospital. The groups consist of a maximum of eight. This is an easily managed group. The areas in the hospital covered on the tour are the departments of radiology, pathology, physiotherapy, emergency, a nursing station, laundry, and dietary. The tour concludes with refreshments in the main dining room. We believe that an important aspect of these tours is that the department head, whenever possible, discusses his department with the visiting group. The press is always invited to these tours, as well as a member of the public relations committee of the hospital.

Planned, written releases are given to the newspapers and radio station whenever feasible. These are always discussed with the representatives of the press and radio in order to explain the purpose of the release, as well as to give a little background story.

The press is invited to all hospital, school of nursing, and auxiliary functions, with the result that good picture coverage is given.

Our public relations committee, composed of the board chairman, two trustees, and two representatives of the community, meet regularly and invite the press. This always results in publicity, usually concerning the efforts being made to have a better hospital, resulting in better community health.

We think that one of the most important phases of our attempt to promote better community relations is the fact that representatives of three newspapers are invited to each regular board meeting. There are definite advantages in this program which outweigh the few disadvantages. It shows the press that there is nothing being hidden from them; the press is being taken into the confidence of the hospital; and the press receives printed financial statements and statistics.

Another important aspect of building good community relations is the selective menu for all patients. We have received as many compliments from patients because of this service as for nursing care given.

The final, and undoubtedly the most important attempt at promoting good community relations, is the way in which we treat our "customers". We give them the best service at a reasonable price. We want them to like our services to the extent that they will talk kindly of them and give us a good reputation. All of our staff members are instructed in courtesy, appearance, and are expected to be tactful, diplomatic, and have pride in doing a good job. We feel that the best good will is built by a satisfied patient.—*A. H. Hewig, Administrator.*

* * *

From Last Month

The following reply to last month's question arrived too late for publication and so is included here. The question was: *Having completed the Extension Course in Hospital Organization and Management, what do you consider was the main value of the course to you?*

St. Paul's Hospital, Saskatoon, Saskatchewan.

THE key to my answer must be in the last two words of the question, "to you".

There is no doubt that each graduate of the extension course gains much in value from it; there is equally little doubt that no two graduates will agree on what was most valuable. Therein lies the secret of the contribution which the course is making to Canadian hospital people and to Canadian hospital administration, and of the success with which it has been attended. There is something in it for everyone, no matter what his background of academic and professional training may have been.

While others may have taken particular pleasure in familiarizing themselves with the detailed operations of the many specialized departments in the hospital, to which

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B.C.H.A. TO EXPAND ACTIVITIES

W. D. Piercey, M.D.

DELEGATES attending the 40th annual convention of the British Columbia Hospital Association decided unanimously to expand the scope of the association in order to render more service to member hospitals. At the meeting, by-laws of the association were amended and a new schedule of dues was adopted to make the expansion possible. Discussions on the urgent necessity of a stronger provincial organization permeated the whole convention which was held in the Vancouver Hotel, October 15-18. Over 400 delegates were present.

The decision to enlarge the work of the association was taken because of continuing differences between the hospitals and the British Columbia Hospital Insurance Service, significant gains by labour in recent union negotiations, the need for strengthening regional meetings, and the need for a central office to act as a clearing house for information among member hospitals. Thus association expansion, B.C.H.I.S., and employer-employee relationships were the three primary topics which dominated the convention program. A large number of trustees participated in the discussion of these subjects.

The attendance of the Hon. Eric Martin, Minister of Health and Welfare, and key personnel of the B.C.H.I.S., throughout the whole convention showed the deep interest taken. The Minister addressed the convention at two separate sessions and Donald Cox, commissioner of the B.C.H.I.S., led a panel discussion during which senior insurance service staff members answered questions.

Keynote addresses were delivered by G. A. Thompson, chairman of the Board of Kimberley and District General Hospital, and by Dr. E. N. Boettcher, medical administrator of St. Joseph's Hospital, Victoria. Mr. Thompson stated that while it was incumbent upon all boards to show an earnest desire to co-operate with the Hospital Insurance Service and the government; boards must also insist that decisions and policies be realistic. If the rate-board cannot come to an agreement with hospitals, a member of the judiciary should be appointed to act as an arbitration officer. There must be a neutral source to provide an unbiased decision. The structure of the present rate-board is inadequate, the speaker claimed.

If the government of British Columbia refuses to co-operate with hospitals in setting up a realistic method of establishing payments to hospitals, then, the speaker suggested, the appointment of a Royal Commission should be made. Should these and all other suggestions be rejected by the government there would seem to be but one course of action open to boards of trustees—resign and let the government operate the hospitals. Mr. Thompson said that an impossible position had been created wherein trustees were being held responsible for conditions over which they had absolutely no control. "We have degenerated into becoming a rubber stamp for the Minister of Health and Welfare. This situation is one which many self-respecting, competent board members are refusing to tolerate any longer. There is an intangible sense of disquiet among trustees which indicates a pressing need for immediate action."

Mr. Thompson also said that trustees are required by law to negotiate in good faith with their employees and that it is the desire of trustees to comply with this requirement. Unfortunately, they have no way of knowing whether they will be able to honour any of their agreements which require additional funds. This is the first condition which the association should seek to rectify, he emphasized. Salary costs and other operating expenses should be finalized before the commencement of the hospital operating year. In the speaker's opinion, it is the duty of the government to provide the necessary funds to pay for the full operating costs or arrange for the hospitals to collect the balance from some other source.

Mr. Thompson believes that the association can assist hospitals in

arriving at equitable salary schedules. He suggested that hospitals should attempt to bargain with their employees on a province-wide basis. He recommended, further, that the hospital year end should coincide with the release of funds by the B.C.H.I.S. He does not believe that this policy need interfere with the statistical year-end reporting on a country-wide basis. Adoption of these suggestions would prove to be more economical for the over-all operation of hospitals in British Columbia, he said.

Dr. Boettcher raised the point that in British Columbia hospital administration focused too much attention on the dollar. Although the government may act as a vehicle in financing hospital care and in providing universal coverage, he said, the basic strength of the hospital system is dependent upon each hospital retaining its autonomy and individual initiative.

The speaker paid tribute to the work which the British Columbia Hospital Association had accomplished in the past on a limited budget. Great credit is due Percy Ward for his leadership and guidance even though he has been acting only on a part-time basis. A hard-working board of directors has also made a significant contribution. However, in the future, he said, it will be necessary to look to the association for more advice and assistance in matters of hospital operation. In the speaker's opinion it is wrong to presume that an agency concerned with the financing of hospitals is in the best position to advise on the proper course to follow in providing an adequate hospital service. Such advice must be coloured by the need for economy.

J. I. Monteith, Chairman of the Board of Kelowna General Hospital, Kelowna; Mrs. G. C. Chandler of Vancouver who is Chairman of the Trustees' Division of the B.C.H.A.; and G. A. Thompson, Chairman of the Board, Kimberley and District General Hospital, Kimberley, are pictured left to right.

Dr. Boettcher cited fixed budgets, the inability of boards to bargain effectively with their employees due to the present budgetary system, and the fact that capital grants in B.C. are made with the provision that the provincial government retain a share of the equity in the hospital, as three factors which limit the autonomy of hospitals. He contended that every effort must be made to guard against any further encroachment.

The British Columbia Hospital Association, Dr. Boettcher believes, must expand the scope of its activities if it is to meet the challenge of the present. A full-time staff is essential as well as the collection of statistical and financial information from each member hospital. The association should act as an information centre for personnel complement, wage scales, and hospital equipment. Such information, when collected and analyzed, would permit the association to help individual hospitals greatly. The speaker also believes it necessary to have an advisory staff available. He cited as examples an administrative consultant, a medical consultant and experts in accounting, nursing, dietary and personnel management. Also needed is an observer in parliament when the Hospital Insurance Service and other hospital matters are being debated.

The Minister of Health and Welfare

The Hon. Eric Martin, Minister of Health and Welfare, said there were 14 hospital construction projects under way. These total 1,318 beds and will cost some $20,250,000. In addition 24 hospital projects are in the planning stage—calling for 1,696 beds, plus 226 beds for nurses and 23 for interns, at an estimated cost of about $31,500,000.

During the past year, he pointed out, B.C. has moved much closer to extending the benefits of hospital insurance to certain types of patients receiving either intensive correctional treatment or rehabilitative services in an approved long-term hospital. Unfortunately, the success of any such plan would be severely diminished if there were

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Above are D. W. Simmons, Comptroller of Royal Columbian Hospital, Vancouver; Harvey Taylor, administrator of West Coast General Hospital, Port Alberni, and 1st vice-president of the C.H.A.; the Reverend J. A. Leahy of Vancouver; and G. C. Saunders, administrator of Chemainus General Hospital, Chemainus.

Participating in the conference were H. R. Slade, administrator of Powell River General Hospital, Powell River, and 2nd vice-president of the B.C.H.A.; J. A. Abrahamson, then president of the B.C.H.A.; Dr. D. F. W. Porter, President of the C.H.A.; and Dr. E. N. Boettcher, medical administrator of St. Joseph's Hospital in Victoria.

Pictured with Sister Rose Wilfrida, Superior, and Sister Margaret, accountant, both of St. Mary's Hospital, New Westminster, are William Lyle, B.C. H.I.S., (left) and Donald M. Cox, Commissioner, B.C.H.I.S.

Left to right: A. H. Rose, A. W. E. Pitkethley, Elvira E. Norlund, James W. Mainguy, and Norman Barr, all representatives of B.C.H.I.S.

Left to right: Sister Vincentia, and Sister Cajetan, nursing supervisors at St. Vincent's Hospital, chat with Sister Marie de Loyola, director of nursing at St. Paul's Hospital and with the operating room supervisor of St. Vincent's Hospital, Sister M. Charlotte, all of Vancouver.

Resolutions

Adopted by the British Columbia Hospitals' Association at its annual meeting.

1. RESOLVED that section (a) of By-law 2 be amended as follows:

Delete the words "One dollar ($1.00) per bed including bassinet calculated on the basis of the official bed capacity, as at the 1st June preceding, as certified in writing by an authorized signing officer of the hospital. In the case of a dispute, the question shall be referred to the Board of Directors of the Society whose decision shall be final insofar as it concerns the dues to be paid by the hospital with which the dispute arises.

In addition to the $1 per bed, each voting member shall pay into the sharing plan, mentioned in section 21, the sum of twenty-five dollars."

And add section (f) as follows:

(f) The dues of all paying members shall be set by a three-quarters majority vote at any annual or special general meeting called for the purpose. Dues shall be calculated on the basis of the official bed capacity of each hospital, excluding bassinets in the nursery, as at the 1st June immediately preceding, as certified in writing by an authorized officer of the hospital. In the case of a dispute, the question shall be referred to the Board of Directors of the Society whose decision shall be final in as far as it concerns the dues to be paid by the hospital with which the dispute arises.

In addition to the amount of dues payable as aforesaid, each voting member shall pay into the sharing plan mentioned in section 21 the sum of twenty-five dollars ($25.00).

2. RESOLVED that section (d) of By-law 35 shall be deleted and the following substituted:

Appoint the senior executive employee of the Society and authorize the employment of such additional employees on such conditions and terms as it deems necessary.

3. RESOLVED that By-law 36 shall be amended by striking out in the second line the words "and all vice-presidents shall be members", and substituting the words "all vice-presidents and the director named by the Trustees' Division shall be members".

4. RESOLVED that the word "deleted" shall be deleted in By-law 16, and that the following be substituted:

The president shall not later than the first day of every annual meeting, appoint a nominating committee which shall, immediately prior to the elections, submit to the members a report recommending the names of persons to be nominated for the office of president and for the offices of vice-president.

5. RESOLVED that this association endorse the actions of the Canadian Hospital Association in May, 1957, in the establishment of a formula for dues from member associations.

6. WHEREAS it is anticipated that our By-laws will be amended to permit any annual or special general meeting to increase or alter the dues payable by each hospital member,

AND WHEREAS this change in our By-laws will not be effective until approved by the Lieutenant Governor-in-Council,

AND WHEREAS it is the desire of the members of the B.C.H.A. that dues be increased at the discretion of the Board of Directors to a maximum of $3.00 per bed, excluding bassinets, with a maximum of 500 beds for any one hospital; plus an assessment of 60 cents per bed for all beds in any given hospital, as an assessment of dues payable by the British Columbia Hospital Association to the Canadian Hospital Association, plus such assessments as are currently in effect, as from August 1st, 1958,

THEREFORE BE IT RESOLVED that the Board of Directors be authorized to increase association dues to voting members in accordance with the foregoing, as soon as all legal procedures have been completed;

and that the Board of Directors be fully authorized to take this action for and on behalf of the assembled delegates at this 1957 annual meeting.

7. RESOLVED that when requested by the Board of Directors, each member hospital contribute to the British Columbia Hospital Association an amount equal to the dues paid in this final year, in order that the association may proceed expeditiously with the expansion of its activities.

8. RESOLVED that the suggestions concerning expansion of association activities as set forth by G. A. Thompson of Kimberley and Dr. E. N. Boettcher of Victoria be endorsed, and that the addresses they gave on Thursday afternoon, October 17th, 1957, be referred to the Board of Directors for study and implementation as far as may be practicable.

9. RESOLVED that this association empower its executive to pursue an investigation into the feasibility of establishing master negotiation machinery, and make representation to the Executive Council of the government, if they so decide, to obtain the necessary legislative amendments required for implementation of such a system.

10. WHEREAS the private hospital division of B.C.H.A. has recently interviewed the Minister of Health and Welfare in respect to an increase in rates,

AND WHEREAS the private hospitals have received a 50c per diem increase in respect to welfare patients,

AND WHEREAS this increase is the first paid to private hospitals in the past five years,

AND WHEREAS the actual increase in cost greatly exceeds the amount granted,

RESOLVED that B.C.H.A. requests the minister to favourably consider a further increase compatible with actual increases in costs, and that a copy of this resolution be sent to the Deputy Minister of Welfare.

11. RESOLVED that this association go on record as favouring, in principle, the employment by hospital boards, on some group or regional basis, of professionally trained management personnel for the purpose of negotiation of labour contracts on a master contract basis.

12. RESOLVED that the B.C.H.A. petition the government of British Columbia to give serious consideration to amending its policy in

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New Canadians and Their Food

Rosamond H. Ross,
Nutrition Consultant,
Metropolitan Health Committee,
Vancouver, B.C.

THE remark of a co-worker, that a Hungarian family whom she had be-friended was having just as much difficulty learning about our foods as about our language, made me stop and think. What responsibility do we, who are working in the health field, whether it be in the community or in the hospital, have in understanding the food patterns of the people of different lands and how do we go about interpreting our so-called "Canadian food pattern" to our new citizens?

Vancouver is one of the most cosmopolitan cities in North America. Here we are fortunate in having the opportunity of meeting people from many lands, including those from China, Japan, India, and all parts of Europe. We have much to learn from these people, as they enrich our culture with their art, music, and philosophy. They also bring with them many ideas about different foods. If we are interested in learning, it is amazing the amount of information that can be gained from these contacts, whether social or professional. A public health nurse from Italy, working on our staff, was able to give us a good insight into the food habits of her people. A visiting doctor from India helped us to understand why the East Indians eat as they do.

There are also other ways we can learn about foreign foods. Many cities have excellent foreign restaurants now and it can be a fascinating activity to try some of their different dishes. At one of our Dietetic Association meetings, we had a most successful banquet when the foods of southern Europe were featured. At the same time, we distributed a pamphlet giving the recipes and some historical background of the foods served.

Another source that can be tapped is the Food and Agriculture Organization office in Washington, D.C. The names and addresses of people in different countries who have an intimate knowledge of the eating habits of their own countrymen can be obtained. From this source we were able to get some excellent material from Japan and Holland.

After learning what we can about the background of these new Canadians, we must consider them here in their new home. First of all, it is our job to see how these people are adapting to our Canadian ways. We can find out much about present eating habits by means of surveys and studies in the schools, by questioning mothers in child health centres, and from observations during home visiting.

In our department, we have made small studies on some Japanese, Italian and East Indian (from the Punjab) families and discovered that certainly their food habits were related to the availability and cost of their own familiar foods, the rate at which they learned English, the social pressures put on them and their children, and how closely their religious beliefs are related to their eating habits. For example, some East Indian children, taking their lunch to school, demanded bread instead of *rotis* because they wanted to be like the other children.

From a study or survey we can organize the foods that are eaten into groups and compare them to the standard, Canada's Food Rules. The following, showing foods selected by groups, illustrates how we went about it with our East Indian study:

Milk

Milk, sour cream, and butter. (Sour cream is sometimes made by combining sour cream and buttermilk.)

Vegetables

A good variety of vegetables; including potatoes, carrots, green beans, peas, spinach, okra, marrow and eggplant. (Generally cooked with spices, and curry and known as *dahl.*)

Fruits

A good variety, including those high in vitamin C.

Cereals

Whole wheat or Hindu flour made into *rotis.* Rice is sometimes used in desserts. (*Rotis* are a pancake-like food eaten as Canadians would eat bread.)

Meat, fish, et cetera

Chicken, canned salmon, mungi (Hindu beans), lentils and eggs. (These are often cooked with butter, spices, and curry. No beef is eaten because of religious beliefs.)

On the whole, the families studied were eating an adequate diet.

In one of our child health centres, we tried to help newly arrived mothers from China appreciate the value of milk. We did it by means of a poster with pictures, pamphlets printed in both English and Chinese, giving the mothers milk to taste, and we used an interpreter—an important member of our team.

In the Hospital

Encouraging patients in hospitals to eat, especially the long-term case, is an important responsibility of all the staff. To new Canadians, being able to eat their familiar foods is probably more important during a period of stress than at any other time and, certainly, illness creates an unusual amount of stress.

In one hospital, different ways have been tried in order to cope with this problem: (a) by planning a flexible menu; for instance, serving rice as well as potato; (b) allowing patients to go out for the occasional meal; and (c) having some of the familiar foods brought in by relatives.

In the Community

There may be people in the community who would like to take the newcomer to a store and explain about labels and packaging, brand names, and even pounds and ounces. Our manner of selling food is so very different from other

(concluded on page 116)

Food Service

sponsored by the

Canadian Dietetic Association

Saskatchewan Hospital Association Convenes

Murray W. Ross

THE annual meeting of the Saskatchewan Hospital Association was held in Regina on October 15th and 16th, followed by a two-day institute on "Operating Problems of Small Hospitals". The latter was conducted by the American Hospital Association in conjunction with the provincial association. Meetings were held in the auditorium of the new and beautiful Museum of Natural History in Regina, with over 170 delegates registered.

The annual meeting was devoted primarily to the business of the association and, inasmuch as Saskatchewan played host to the Canadian Hospital Convention earlier in the year, the usual commercial and scientific exhibits were absent. The invocation at the opening session was given by Rev. Father C. S. Godin of Moose Jaw.

Problem of Capital Costs

In extending a warm welcome to the delegates on behalf of the City of Regina, His Worship, Mayor T. H. Cowburn expressed the hope that solutions would be sought to the problem of providing an equitable basis for the distribution of the capital cost of hospitals which, he felt, now placed an unfair share of the burden on the community.

The Hon. J. Walter Erb, Minister of Public Health for Saskatchewan, expressed agreement in principle with his worship and hoped that the Government of Canada was fully aware of such hospital problems. Mr. Erb stated that he was impressed with the spirit of co-operation which prevailed between hospital trustees and the public health officials of the province, and between the hospital association and the department. While cordially greeting the delegates on behalf of the Government, the Minister expressed interest in the character and scope of the developing plan for regional hospital councils in the province and hoped that this program would be continued and expanded.

Greetings from the American Hospital Association were conveyed by Jack W. Owen of Chicago. Murray Ross extended the good wishes of the Canadian Hospital Association, and presented a report on activities of that body.

Annual Reports

A summary of the year's work in the form of a written report of the Executive Committee of the Saskatchewan Hospital Association was presented by the president, E. F. Bourassa, Regina. The report dealt with the appointment of Philip Rickard as executive director, to succeed the late E. V. Walshaw; the establishment of a permanent secretariat located in Regina; the disposition of all resolutions passed at the previous annual meeting; and the work accomplished by various committees and sub-committees.

Members of the Executive Committee and sub-committee chairmen elaborated and led discussion on the various items in the report. Speakers included E. F. Bourassa, Regina; H. H. Bassett, Prince Albert; C. E. Barton, Regina; P. A. Rickard, Regina; N. A. Hall, Shaunavon; J. L. Fawcett, Rosthern; Dr. A. L. Swanson, Saskatoon; W. C. Hibbert, Wadena; W. O'Neill, Saskatoon; and M. F. Kushnir, Canora. The subjects discussed, many of which subsequently found expression in resolutions, included the Health Services Planning Commission, capital costs, central lecture program for nurses, bursaries for technical personnel and financial aid for student nurses, constitution and membership fees, Red Cross blood transfusion service, and association finances.

Miss K. Francis of Yorkton reported on behalf of a committee

Executive Committee of Saskatchewan Hospital Association, 1957-58:
Front row, left to right: Eugene F. Bourassa, Regina, past-president; Charles E. Barton, Regina, president; M. F. Kushnir, Canora, vice-president.
Back row, left to right: N. A. Hall, Shaunavon; D. Z. Daniels, Canora; W. O'Neill, Saskatoon; Philip Rickard, Regina, Executive Director; Dr. A. L. Swanson, Saskatoon; and W. C. Hibbert, Wadena.

studying the nursing assistant training program. The study is to extend over a one-year period and will cover recruitment, curriculum, and training facilities.

The report of E. L. Casey of Saskatoon indicated that an interim edition of the Canadian Hospital Accounting Manual would be made available to hospitals before the end of the current year and that the final revision, in the form of the second edition, would be completed sometime in 1958, after the requirements resulting from the federal-provincial agreements for hospital insurance became better known. The report anticipated that institutes on hospital accounting, dealing with the revised account classifications, et cetera, would probably be held in the province before the end of the year.

Auxiliaries

Mrs. W. C. King of Estevan, president of the Saskatchewan Hospital Auxiliaries Association, reported on the activities of auxiliaries in the province. A total of 93 auxiliary groups are now functioning and assisting their hospitals through fund raising, public relations, and volunteer services. Mrs. King reported the allocation of two W. J. Moore bursaries to nurses, as well as the association's own bursary, each for the sum of $100. She expressed the association's pleasure at the election of Mrs. Mabel Frost of Saskatoon as first vice-president of the National Council of Women's Hospital Auxiliaries of Canada at its biennial meeting in May. In connection with that meeting, Mrs. King thanked the officers and members of the Saskatchewan Hospital Association for the facilities provided and the co-operation extended which contributed so largely to its success.

Future Needs

A lively and interesting round table discussion was lead by Dr. F. B. Roth, Deputy Minister of Public Health, and E. F. Bourassa. The discussion centered around the future rôle of the hospital and how hospitals should develop in Canada, particularly in Saskatchewan.

The subject matter was discussed under four main headings, namely: the traditional treatment, restorative, or curative rôle; preventive service, clinics and centres for early detection of disease; educational programs for personnel and community; and as centres of research into the medical, psychological, and social aspects of disease.

Institute Program

At the conclusion of the two-day business meeting of the S.H.A., a two-day institute on the operating problems of small hospitals was conducted under the direction of Jack W. Owen of Chicago, staff representative of the American Hospital Association. Over 140 people attended.

William O'Neill of St. Paul's Hospital, Saskatoon, set forth, in a capable fashion, principles of administration and their importance in hospitals of all sizes. He then presided over a panel discussion on the application of good administration practices. The question was handled, from the viewpoint of the medical profession, by Dr. G. W.

Left to right: T. Gauley, Unity; C. R. Henderson, Saskatoon; W. D. Taylor, Wolseley; Percy Howe, Lloydminster; Eugene Michayluk, Davidson; Edwin G. Thacker, Turtleford; and N. R. Werezak, Unity.

Left to right: Sister Mary Hilary, Weyburn; Henry A. Connolly, Victoria Hospital, Winnipeg; Sister Marie Claudia, Montmartre; L. A. Fetter, Eastend; Helen Talpash, Swift Current; and Cecil Sloan, Swift Current.

Peacock of Saskatoon, registrar of the College of Physicians and Surgeons of Saskatchewan. Mrs. M. M. Aikenhead of Melfort Union Hospital spoke as a director of nursing. The administrator's responsibilities were presented by Peter Swerhone of North Battleford.

Following the presentation of a paper on the trustee's rôle in hospital operation by Dr. H. S. Jamieson, chairman of the board of the Moosomin Union Hospital, Charles E. Barton, assistant superintendent of Regina General Hospital, acted as moderator in a panel discussion. Participating in this discussion were Patricia McGrath of Regina, nursing consultant, Department of Public Health, and Dr. M. C. Novak, superintendent of Yorkton General Hospital. J. W. Owen of Chicago spoke on "Communications and its rôle in working with people".

Philip Rickard presided over an interesting panel on the possibility of sharing services of professional and technical staff among several smaller hospitals. The services discussed included accounting, medical social work, and dietetics et cetera. Cecil J. A. Sloan of Swift Current, co-ordinator of the South-West Regional Hospital Council, and H. H. Bassett of Prince Albert participated in the discussion in which the sharing of services was linked with the developing regional hospital program in the province.

Federal hospital insurance proposals, and the present status of federal-provincial negotiations on plans, were reviewed by Dr. F. B. Roth, Deputy Minister of Public Health.

Purchasing and stock control in small hospitals was the subject of presentations by E. L. Casey of Saskatoon, comptroller of the University Hospital, and Cyril M. MacKay of Regina, accounting consultant, Division of Hospital Administration and Standards, Department of Public Health. This was followed by a question and answer period.

Resolutions

Dr. Arnold L. Swanson of Saskatoon, executive director of the University Hospital, acted as chairman and presented the report of the Resolutions Committee. Several periods during the business meeting of the association were devoted to debating some fourteen major resolutions.

It was decided to forward a recommendation to the hospital associations of Manitoba, Alberta, and British Columbia to the effect that the executive officers of the four western associations meet at least annually. The purpose of such meetings would be to discuss hospital problems common to the associations and to hospitals in the four provinces. It was mentioned that probably at least two representatives from each association would attend such meetings.

The government of Saskatchewan has recently announced that a limited number of hospitals, whose accounting and budgeting performance has been satisfactory, would be allowed to present budgets for succeeding years in the month of October, based on nine months actual experience in the current year. This action was endorsed, and the government was urged to extend this policy to embrace all possible member hospitals.

Recommendations concerning personnel policies presented to individual hospitals by professional organizations will, henceforth, be reviewed by the executive of the association. Wherever possible recommendations will be made to member hospitals to serve as a guide in reaching decisions on such matters. The executive of the S.H.A. was empowered to negotiate with third party paying agencies for standardization of charges for out-patient services.

The government was asked to fix financial responsibility for the cost of hospitalizing patients awaiting transfer to welfare or other institutions, following termination of their coverage under the insurance plan. It was pointed out that residents of the province frequently failed to pay their hospitalization tax by the closing date and were

Above, left to right: Sister Marie Ephrem, Zenon Park; Sister Francoise Beaudoin, Gravelbourg; Sister Margaret Marie, Prince Albert; Sister Theresa of Sacred Heart, Esterhazy; Sister Marie de L'Ange Gardien, Ponteix.

Below, left to right: F. Tatlow, Melfort; Donald A. MacMillan, Yorkton; Mrs. M. M. Aikenhead, Melfort; E. Gordon King, Lloydminster; J. P. Peeters, Nipawin; Dr. M. C. Novak, Yorkton; A. W. Holtby, Melfort; Richard A. Popp, Langenburg.

not eligible for benefits under the insurance plan for a period of thirty days following payment, during which time hospitalization was often provided. The insurance plan was requested to make all possible effort to have the tax paid by the beginning of the effective period. Similarly the government was asked to give consideration to withholding motor vehicle operators' licences and motor vehicle licences, under certain circumstances, unless hospitalization coverage was established. A suggestion to the Department of Social Welfare to the effect that municipalities paying hospitalization tax for metis be reimbursed by the department and, at the same time, the government was requested to waive the thirty-day waiting period for such patients.

Many speakers during the meeting made reference to the inability of local communities to bear a large share of the capital cost of constructing hospitals and equal concern over the question of capital debt and carrying charges on capital debt when a national hospital plan comes into operation. A resolution directed to the Saskatchewan Department of Public Health, and to the Canadian Hospital Association for transmission to the Department of National Health and Welfare, set out the following requests:

1. to substantially increase the amount available through national health grants to individual hospitals for hospital construction, and

2. to include, in provincial and national hospitalization programs, payments for depreciation costs on buildings and for carrying charges on capital debt and, in particular, that cognizance be taken of the special difficulties that are experienced by those hospitals where capital debt is not guaranteed by any level of government.

Numerous submissions have been made to the Indian Health Services Branch of the Department of National Health and Welfare requesting the adjustment of hospital charges paid for treaty Indians on a retroactive basis in the same way as rates are adjusted under the Saskatchewan Hospital Services Plan, without result. The association was directed to continue to press for the correction of this obvious injustice.

It was decided to petition the Department of National Revenue for the exemption of regional hospital councils from the payment of federal sales tax. The feeling was

(concluded on page 116)

Left to right: G. A. Medhurst, Wilkie; Trevor Quinn, Swift Current; Emma Bartel, Kipling; Mrs. E. M. Rudolph, Gull Lake; Mary C. Kearns, Kipling; Dr. H. E. Appleyard, Regina; and W. J. Moore, Wilkie.

Left to right: Sister Mary Esther, Estevan; Sister Irene Drouin, Gravelbourg; Sister M. Elizabeth, Melville; Sister Priscilla, Peterborough, Ont.; Sister M. Patrice, Regina; and Sister Mary Hugh, Broadview.

Left to right: H. H. Bassett, Prince Albert; E. V. Wahn, Saskatoon; Marjorie Black, Regina; J. L. Fawcett, Rosthern; Philip Rickard, Regina; Peter Swerhone, North Battleford; Patricia McGrath, Regina and Dr. J. A. Matheson, Moose Jaw.

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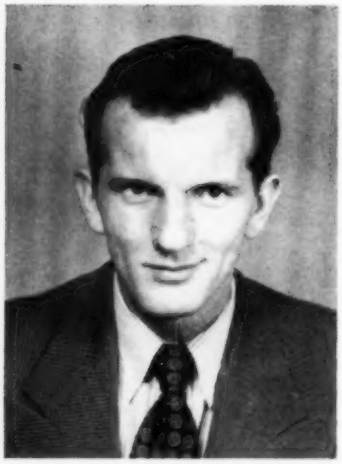
(continued from page 48)



J. E. Bragg

Joseph A. Ricciatti, secretary-treasurer, Kirkland and District Hospital, Kirkland Lake, Ont.

George J. Riesz, assistant administrator, New Mount Sinai Hospital, Toronto, Ont.

Sister Rose Marie Prieur, assistant administrator, Hôtel-Dieu of St. Joseph, Windsor, Ont.

Sister M. St. Paul, administrator, St. Joseph's General Hospital, Brantford, Ont.

Bertram George Thacker, superintendent, St. Thomas-Elgin General Hospital, St. Thomas, Ont.

Gerald Philip Turner, assistant administrator, New Mount Sinai, Hospital, Toronto, Ont.

(see also page 64)

Joseph A. Ricciatti

Howard K. Krafft

Bertram G. Thacker

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Illustrated are installations in the new School for Mental Defectives, at Portage La Prairie, Manitoba, which incorporates many of the most modern features in construction and equipment developed for such institutions.

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Douglas R. Peart

Clifford F. Ellis

Grants Brief

(continued from page 35)

great an obstacle as the cost of all departments and areas are included in the total cost. On the other hand, the restriction is both significant and serious when an addition is made for diagnostic areas, educational facilities, or supporting services, which have little or no effect on bed capacity. The same is true when such areas are obsolete or otherwise inadequate and must be extended or rebuilt. Many hospitals are grossly deficient in supporting services and special professional departments. Often these are required, with only a modest addition of beds.

We believe that under national hospital insurance there will be an increased utilization of all hospital facilities. There will be a demand for improved and up-to-date services in hospital departments where these are now provided only partially if at all. Adequate areas must be provided for diagnostic facilities and treatment services for both in-patients and out-patients. Economy and efficiency in operation, on the other hand, will require effective administrative areas and supporting services.

Operating and recovery rooms, laboratories, pharmacies, physical and occupational therapy departments, would be among the diagnostic and therapeutic facilities referred to in the preceding paragraphs. Supporting services would include kitchens, power and heating plants, laundries, et cetera. We believe that greater emphasis on such departmental areas and federal assistance for their construction or replacement would greatly strengthen the whole hospital construction program.

Educational facilities for the teaching and accommodation of nurses and nursing assistants, medical interns, dietitians, and technicians are essential to maintaining an adequate supply of professional and technical personnel. While certain assistance is now available for such purposes, it is again limited by such conditions as the provision of additional beds. This portion of the program would be greatly improved by broadening the application of construction grants to include all educational facilities, and all residence accommodation connected therewith.

We respectfully recommend that the scope of the hospital construction grants be broadened so that eligibility for grant assistance may be extended to construction projects involving *any area, department, or service in a hospital, and any educational facility or residence accommodation.*

Amount of the Grants

During the post-war period the cost of all types of construction has greatly increased. Taking 1949 as equal to 100, the price index for building materials in 1955 stood at 123.4 and wage rates in construction industries at 145.4. Similar advances in the cost of hospital equipment have taken place. Although we do not like to use the phrase "cost per bed", nevertheless, the upward trend is evidenced by the following average costs, by year of completion, for the construction of new active treatment hospital beds:

1949-50	$ 6,300
1950-51	8,100
1951-52	11,300
1952-53	13,400
1953-54	13,300
1954-55	13,500

Increased costs of labour and material are not the only factors which influence the cost of hospital construction. Advances in medical science reflect themselves in hospital design and there is a continuing effort to plan hospitals so that they may be operated more efficiently. These changes contribute to higher capital cost at the time of construction but often materially assist in the never-ending task of holding operating costs to the lowest minimum, consistent with acceptable standards of patient care.

Developments in hospital therapeutics are affecting hospital design by leading to the inclusion of such items as duplicate utility rooms, examination and treatment rooms, piped oxygen outlets in each patient's room and treatment area, clinical teaching rooms, and up-patient dining rooms.

There is evident need of more and larger post-operative rooms and a trend to the development of post-delivery recovery rooms in the obstetrical service. As integration between in-patient and out-patient care grows, the need increases for observation and holding rooms, utility rooms, and other facilities in out-patient areas. Greater interest in geriatrics and the needs of an aging population, and an increasing awareness of the value of rehabilitation, will require additional space for diagnostic facilities and treatment services.

Among the items likely to be included in modern hospital design which will increase the initial cost of a hospital but at the same time materially contribute to efficient operation are pneumatic tubes, telautograph systems, central dictating systems and the freer use of dumb-waiters, elevators, and other means of inter-communication. In a similar category are adequate facilities for purchasing and stores departments and other administrative services.

Raising funds to build a new hospital or to provide an addition to an existing hospital is one of the major problems facing hospital boards. It is a problem which has become increasingly serious during the past few years and now frequently presents an insurmount-

(continued on page 114)

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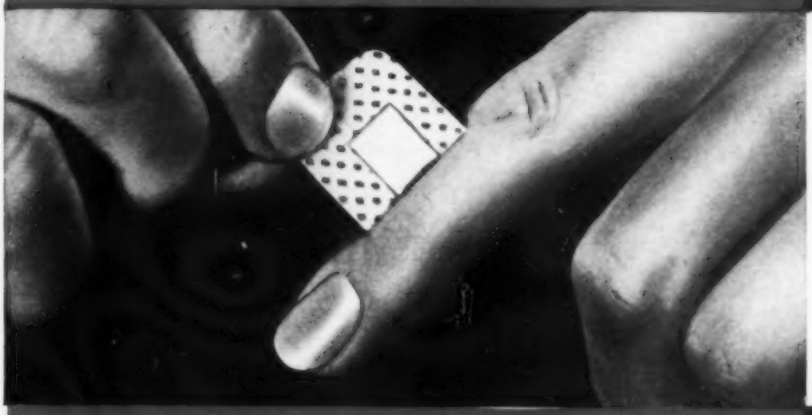

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Provincial Notes

British Columbia

Fraser Canyon Hospital Association has accepted a tender for the new hospital designed by Anderson and Raymer, of Chilliwack, and construction of the building is under way.

A hospital district is being formed at Williams Lake for the construction of a new hospital. Whittaker & Wagg of Victoria have been appointed as architects.

The new 314-bed addition to Shaughnessy Hospital, Vancouver, will also provide an arts and crafts room, rehabilitation offices, and staff quarters and facilities. The six-floor building was designed in a T-shape by architects Mercer & Mercer.

The addition to Burnaby General Hospital will be constructed by a Vancouver firm. The five-storey addition, designed by architects Gardiner, Thornton, Gathe & Associates, will include new administrative offices and a laboratory as well as provision for 125 beds, 30 bassinets, surgical suite and laundry facilities.

A 50-bed hospital in Penticton to care for long-term patients is planned to adjoin the Penticton General Hospital. The $100,000 private hospital to be built by R. E. Gingell of Vancouver would serve the whole Okanagan Valley, and relieve the general hospital. This two-level site would provide the quiet essential to long-term patients.

The new Campbell River and District Hospital was opened in September by the Hon. Eric Martin, minister of health and welfare. The $1,250,000, 74-bed building will replace the 44-bed Lourdes Hospital, at Campbell River.

Ladysmith General Hospital is giving the "open hours" visiting system a trial period of one month. If it proves successful the new system will be adopted.

Alberta

Sketch plans are being prepared by architects Callebut, Gordon & Mangold, of Edmonton, for a senior citizens' hospital in the Municipality of Wainright. The structure of frame and wood siding is to cost an estimated $150,000.

Construction of the new clinical services addition to University of Alberta Hospital in Edmonton is beginning this fall. The six-storey structure will serve as the hospital's admitting department and emergency area.

The contract has been awarded for an addition to the east wing of Edmonton's Royal Alexandra Hospital. Construction of the five-storey extension, involving the demolition of the sun verandah, will provide additional space for beds and for an x-ray department. The architects are Rule, Wynn & Rule.

Unrestricted visiting of patients in Calgary General Hospital is no longer on a trial basis. The new visiting system is successfully relieving the congestion and disturbance of a more rigid schedule.

A 25-bed hospital is to be erected for Cold Lake by the Women's Missionary Society of the United Church of Canada. The contract has been awarded for the frame and stucco building designed by architects McKernan & Bouey.

Sketch plans are being prepared by architects Diamond, Dupuis and Dunn, of Edmonton, for a 75-bed hospital unit in St. Paul.

The ceremony which opened the new nurses' residence at Holy Cross Hospital in Calgary also marked the hospital's golden jubilee. The new eight-storey building will provide a home for 250 nurses, and contains an auditorium in the basement.

Construction of new and enlarged facilities for the mentally ill in Alberta will cost approximately $4,150,000. A new laundry building is to be built at the Mental Institute at Oliver, Alta., an extension to the nurses' residence at the Provincial Mental Hospital, Ponoka, is planned. A new clinic building at the Provincial Training School at Red Deer, Alta., is nearing completion, and two dormitories are being built at the Deerhome Institute for adult mental defectives.

Saskatchewan

The five-bed addition to Paradise Union Hospital at Paradise Hill will provide operating and case rooms, and a nursery. Designed by architects Webster & Gilbert of Saskatoon, the project will cost approximately $33,000.

The contract for construction of a nurses' residence at Swift Current, designed by architect H. K. Black of Regina, has been awarded to a local contractor.

Manitoba

The Portage District Hospital board in Portage La Prairie has decided to grant an increase of $25 to nurses, and $10 a month to office, kitchen, and laundry staffs.

The Flin Flon General Hospital plans a one-storey addition to the present building to increase its capacity from 75 to 99 beds.

In order to meet the cost of its current construction program, the Winnipeg General Hospital has floated a $2,000,000 issue of debentures to mature in 1977. These are to be sold by a syndicate, are non-callable, and unconditionally guaranteed by the City of Winnipeg.

The Victoria General Hospital in Winnipeg has been bequested the residue of the Robert Alexander Taylor estate. Formerly a farmer of LaSalle district of Manitoba, Mr. Taylor also made bequests to two other institutions in the province.

Ontario

Lakeshore General Hospital, the smallest in the Metropolitan Toronto area, was opened this summer to assure rapid treatment to local accident victims. Before renovations the building was used as an x-ray laboratory. Now, although its hospital has only seven beds and must arrange entry into a larger hospital for patients requiring care for more than a few days, the town of New Toronto has most of the facilities available in any general hospital.

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the treatment of crippled children will rise to eight floors instead of the originally-planned two. To finance this new wing of War Memorial Children's Hospital, another $100,000 must be raised in addition to grants and the $250,000 already collected in campaigns by Easter Seal service clubs.

Cobourg General Hospital, faced with a financial crisis when the lowest tender proved to be $226,000 higher than the cost originally estimated, has decided to appeal for more federal and provincial aid. The proposed extension would increase its present capacity by 80 beds.

Quebec

Ste. Agathe des Monts is planning a 24-bed addition of two storeys and a basement extension. To cost an estimated $200,000, the extension was designed by architect Jean Guy Clement of Ste. Agathe.

The new Ste. Justine Hospital for Children was inaugurated on the 50th anniversary of the founding of the original Ste. Justine Hospital in Montreal. The 860 beds and 70 cribs in the new building will be able to treat an estimated 20,000 children annually.

New Brunswick

When St. Joseph's Hospital, Saint John, moves into its new building its capacity will be increased from 116 beds to 205 beds and 50 bassinets. After December the present premises are scheduled to be converted for use as a combined nursing school and nurses' residence.

A new electrocardiograph has been donated to the Tobique Valley Hospital in Plaster Rock. The diagnostic apparatus is valued at $900.

Prince Edward Island

A miniature chest x-ray unit was installed in the Prince County Hospital at Summerside. The new equipment, enabling every patient admitted to receive a free chest x-ray, was provided by the P.E.I. Tuberculosis League.

Nova Scotia

Efforts of the fire department confined a recent blaze in the Digby General Hospital to the top floor. Although $1,500 damage was caused by the flames, water, and smoke, the patients in the hospital suffered no serious effect from the fire.

The Digby General Hospital was presented with a gas-oxygen anaesthetic machine on behalf of the ship's fund and the ship's company of *H.M.C.S. Buckingham.*

Newfoundland

Construction of the Carbonear Community Red Cross Hospital is greatly aided by voluntary services. The brick, two-storey building designed by architect Powell will provide two wards and several private rooms, with staff quarters on the second floor. The distance of Carbonear from St. John's makes the hospital a necessity for the community.

Nurse Training for Ex-Tuberculosis Patients

A new scheme of training for ex-tuberculosis patients who wish to become nurses is to operate at Grove Park Hospital, London. By this new scheme it is hoped that many ex-patients, who after treatment are often attracted to nursing and find it difficult to be accepted by a general hospital, or for whom the work would be too hard, will be recruited. By starting in the chest hospital in which they have been patients, students can be assured that they will be under medical supervision, and that their nursing duties can be adapted to their physical abilities at each stage of their training. After two years when they are fully rehabilitated they can go on to Lewisham (General) Hospital to complete their training for state registration, and on obtaining this qualification all the many branches of the nursing profession should be open to them. All students during the two years at Grove Park Hospital can also obtain the certificate of the British Tuberculosis Association so that at the end of four years they have two qualifications. This scheme replaces the old affiliated training scheme and has the provisional approval for one year of the General Nursing Council. It is hoped that eventually as much as 50 per cent of the nursing staff may be ex-patients. The scheme is framed with a dual purpose, to enable ex-tuberculosis patients to take up nursing under medical supervision and to provide badly needed nursing recruits for Grove Park Hospital.—*The Hospital.*

more difficult problem to approach but this problem can also be kept within reasonable limits through the full co-operation of all members of the Ontario Medical Association, including radiologists.

Provision of radiological services in sanatoria for tuberculosis and the out-patient clinics conducted by them is a specialized field of medicine and is best provided by those who are responsible for the clinical care of patients in these institutions. A radiologist should be enlisted as a consultant member of their staffs to assist in diagnostic problems of a more general nature. Again in reference to the Ontario mental hospitals, more extensive radiological coverage will be required along with other advances in treatment. Until more radiologists become available a part-time consultant to these institutions must suffice.

The private offices of certified radiologists and the departments of radiology of some of the larger clinic groups in Ontario cities provide a very significant percentage of the diagnostic radiology done in the province. For example, in the city of Hamilton such services represent slightly more than half of the total number of examinations performed in the area, despite the presence of two large general hospitals. The quality of work provided in this way is of the highest as very often there is a direct radiologist-patient contact which can not always be obtained in the very busy hospital department. These services must be utilized to their fullest to cover the increased load of a diagnostic health plan designed for the majority of people in the province. It is the feeling of the Section of Radiology and of the Ontario Medical Association that coverage of examinations done in such private offices and clinics should be provided at the same time that outpatient coverage in hospital departments of radiology is introduced.

Provision of services in general practitioners' offices, the offices of specialists certified in fields other than diagnostic radiology and in clinics where the films are not interpreted by a certified radiologist also comprise an appreciable number of the diagnostic studies done during a year. The Ontario Medical Association estimates well over 200 such offices where x-ray equipment is installed and in many localities no other x-ray facilities are available. The Workmen's Compensation Board and the Ontario Medical Association Tariff both recognize the use of this equipment but only pay 75 per cent of the full fee for examinations performed in these offices and interpreted by a physician not certified in diagnostic radiology. Further, the Workmen's Compensation Board reserves the right to refuse payment for services rendered to injured workmen in any x-ray office or department of radiology if the quality of the examination as shown by the films and report rendered is not up to standards arbitrated by their consultants in radiology. It is my belief that the x-ray facilities enumerated above could eventually render valuable service in a health insurance scheme. The Section of Radiology, through the Ontario Medical Association, would again be prepared to assist in extending coverage to patients examined in these facilities, using some type of control such as that outlined above in workmen's compensation cases.

Provision of services in outlying areas of the province is somewhat tied in with the previous discussion as, at the present, this is the only service available. During the initial phases of development of health insurance in Ontario, these outlying areas will continue to be covered in this way. The question is whether to make facilities universally available by government subsidy over and above the usual cost of the service provided or to have the government develop its own diagnostic centres in outlying areas. This problem will require much further study to reach the most economical solution without jeopardizing quality of service.

Payment for these diagnostic radiological services must, of course, cover the entire cost of performing the examination. The Premier of Ontario has already stated this general principle as applying to all services provided in a hospital insurance scheme. The cost factors in a radiological examination are:

(1) The cost of supplying and servicing the space necessary for a department of radiology or similar establishment and for the very specialized and expensive equipment used in it. This can be calculated on a yearly basis, as a rental figure for the space provided and a depreciation figure for the equipment, including technical obsolescence as well as long use.

(2) The salaries of all non-medical personnel necessary for the efficient operation of the department.

(3) The cost of expendable supplies and materials.

(4) The physician's fees for his interpretation and consultation, where necessary, on each case examined in the department or establishment giving the service.

I cannot stress too strongly that the high quality of diagnosis provided by a department of radiology, a radiologist's private office or other establishment, depends on this fee-for-service principle. It is based on the fact that a radiologist is a physician who has trained for five years over and above his regular medical course in a specialty which must be cognizant of the whole field of medicine to be of maximum value. His service of interpretation of a patient's films, including examination of the patient wherever possible and consultation with the referring physician, is a consultation just as much as a consultation provided by an internist, surgeon or any other specialist of comparable training and recognition. His opinion often proves to be the deciding factor in ultimate treatment, whether surgical, medical or even obstetrical. Nothing must interfere with this opinion being of the highest quality or the whole standard of medicine will deteriorate. He is entitled to some economic arrangement which will provide him with the equivalent of an individual fee for each opinion rendered, just as much as any other physician or surgeon. The scale of these fees must be computed in such a way that their total during a year, assuming a reasonable volume of total work done, will be comparable to the incomes of other physicians of similar training and experience. Otherwise, in the choice of fields of medicine, which all young graduates have, radiology will attract only the mediocre and those satisfied to perform the mere service of film-reading rather than a medical consultation.

With this all-important preamble, let us examine the methods of remuneration of radiologists which are in general use now or which might come into effect in the future.

(continued on page 100)

Catholic Hospital Conference of Alberta

THE 14th annual meeting of the Catholic Conference of Alberta was held in the auditorium of Holy Cross Hospital, Calgary, on September 12th and 13th, 1957. The keynote was given in a sermon delivered by His Excellency, Bishop Carroll of Calgary, at the opening of the two-day meeting. Bishop Carroll stressed the theme of the conference: "For We Are God's Coadjutors".

The first day, following the Mass, there was registration of delegates in the new auditorium of Holy Cross Hospital School of Nursing.

Opening remarks were made by Reverend Francis MacKay, the spiritual advisor. Greetings from the city of Calgary were given by Donald H. MacKay, mayor of Calgary. Reverend J. J. Flanagan, S.J., executive director of the Catholic Hospital Association of the United States and Canada, brought greetings from that organization. Greetings from the Catholic Hospital Association of Canada were delivered by Reverend F. J. Smyth, acting executive director of the Catholic Hospital Association of Canada. Acting for Victor Pryce, president of Associated Hospitals of Alberta, Dr. H. P. Wright of Calgary gave a few words of welcome on behalf of that organization. The final words of greeting to the assembled delegates were given by Mrs. Clara Van Dusen, R.N., secretary-registrar of the Alberta Association of Registered Nurses.

The business session was presided over by Sister M. Loyola, president of the Catholic Hospital Conference of Alberta. Reports were delivered by the president, Sister Loyola, and by the executive secretary-treasurer, Sister M. P. Rheault, s.g.m. The reports of the standing committees were also given at this session on Thursday morning.

Two major addresses were delivered to the convention delegates by Reverend J. J. Flanagan, S.J., from St. Louis, Mo., and Reverend Francis J. Smyth of Ottawa.

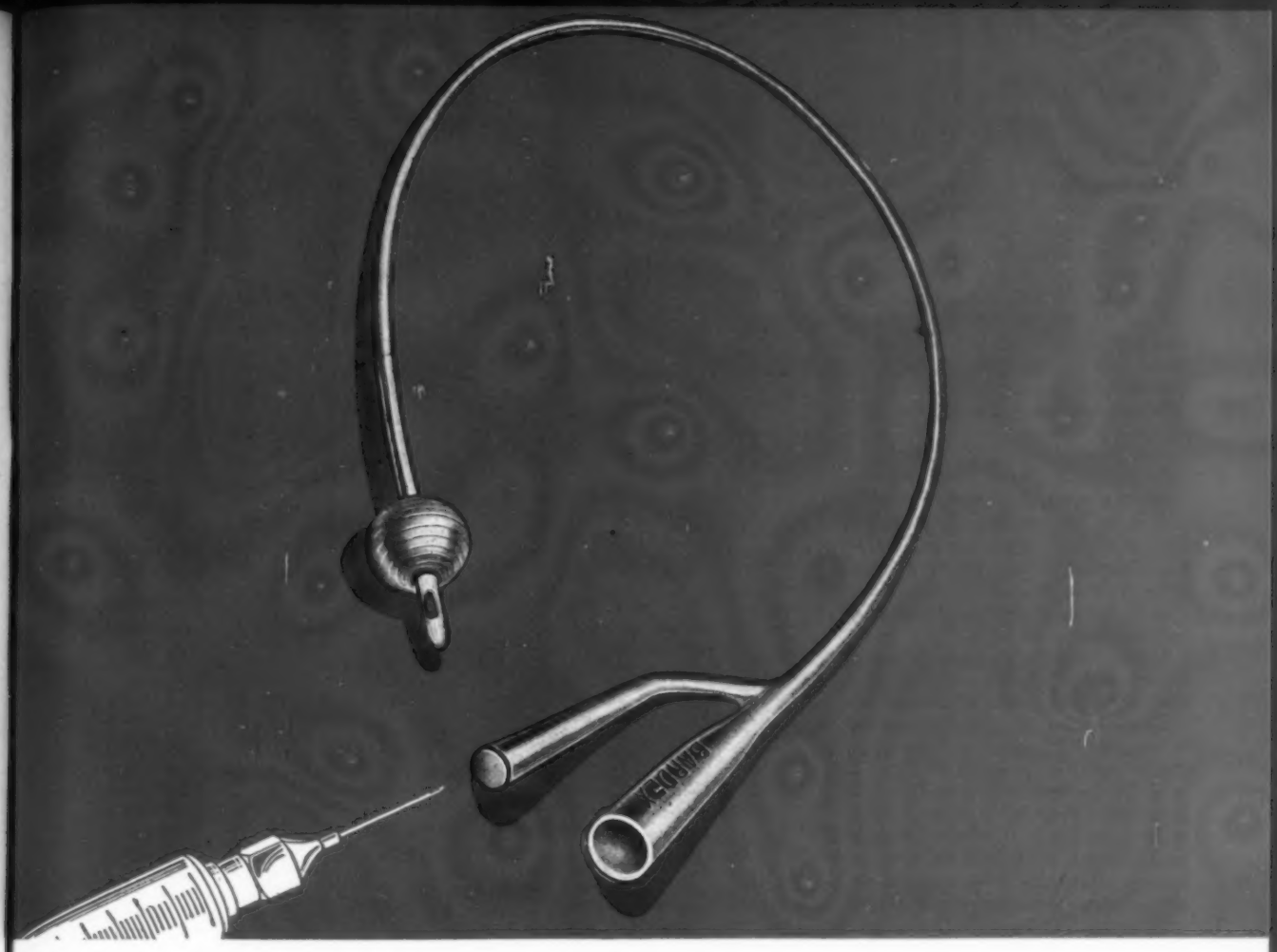
Father Flanagan spoke on "Justice in Relation to Employer-Employee, and Employee - Employer". He emphasized the fact that many Catholic hospitals are now big business organizations but that they must not lose the spirit of charity and sympathy in the care of the sick. The administration of any Catholic hospital must be carried out with a firm sense of justice—on the part of employer and employee. It must always be kept in mind that an adequate living wage must be paid all hospital personnel for an honest day's work. The cost per patient must be solved by good administration and shrewd buying on the part of the purchasing agent, not by an automatic increase of patients' fees. In addition, Father Flanagan mentioned that a thorough job description should be outlined to personnel; that they should be supplied with written personnel policies and an approved wage scale for their perusal.

Father Smyth, acting executive director of the Catholic Hospital Council of Canada, and director of the Social Action Department (English-speaking Section) of the Canadian Catholic Conference, gave an enlightening address on the "hospital apostolate". He then went on to outline the rôles of those connected with hospitals; the doctors, the dietitians, the pharmacists and the nurses. He described their different types of work.

On Thursday afternoon, C. W. Daniel, a petroleum engineer, demonstrated and explained some ideas for good business management and pointed out the need for delegating responsibility to supervisors. He stressed this as one of the most important functions of good management. This idea was confirmed later in a panel discussion, led by Sister Denise Marguerite.

Reports on the Catholic Hospital Association of Canada and on the

The new executive members of the Catholic Hospital Conference of Alberta are, from left to right: Reverend Francis MacKay, Bishop's Representative; Victor Pryce, President of the Associated Hospitals of Alberta and Public Relations Officer of the C.H.C.A.; Sister Maria James, Hardisty, 1st Vice-president; Sister M. Loyola, Galahad, President; Sister Mary, 2nd Vice-president, Barrhead; Sister M. P. Rheault, Executive secretary-treasurer, Edmonton, Alta. Reverend Francis Smyth, on the far right, Executive Director of the C.H.A.C., Ottawa, Ont., also attended.



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SUMMIT, NEW JERSEY

Canadian Hospital Association biennial meeting in Saskatoon were delivered by Sister Geralda and Sister Sylvia.

At a banquet following the first day's sessions F. Howard Kelly, a Calgary lawyer, spoke on labour problems from a human relations point of view, stressing the human aspect in employer-employee relations. During the banquet, several choir selections were presented by little tots of St. Charles School in Calgary. A delightful musical film brought the first day of the convention to a close.

On Friday morning, His Grace, Archbishop Anthony Jordan, o.m.i., coadjutor Archbishop of Edmonton, spoke on the chaplain's rôle in the hospital. His Grace stressed that the chaplain is in a position to relieve a sick person from anxiety and to bring untold peace and comfort to a suffering soul.

Sister Laramee, s.g.m., delivered a very impressive talk on vocations and on the means of attracting more people to the religious life. A committee meeting completed the morning session on Friday.

On Friday afternoon there was a panel discussion by the Holy Cross nurses on their Catholic nurses' organization. This was followed by a very entertaining skit, performed by the same nurses, bringing the convention to a close.

There were 53 delegates present, as well as various other hospital personnel. The Catholic Hospital Conference feels that the 14th annual convention was quite successful and highly practical. "Through an interchange of ideas and methods we are gradually drawing nearer the rôle of God's coadjutors. To settle for anything less would not be in accordance with the teaching of God regarding the care of His sick and unfortunate."

The new slate of officers for this year is: *Honorary president*, Most Reverend J. H. MacDonald, D.D., Archbishop of Edmonton; *President*, Sister M. Lovola, c.s.j., St. Joseph's Hospital, Galahad; *First vice-president*, Sister Maria James, St. Anne's Hospital, Hardisty; *Second vice-president*, Sister Mary, c.sj., St. Joseph's Hospital, Barrhead; *Executive secretary-treasurer* Sister M. P. Rheault, s.g.m., Edmonton General Hospital, Edmonton; *Chaplain and Bishop's representative*, Reverend Francis MacKay, Claresholm; and *Public Relations officer*, Victor Pryce, Holy Cross Hospital, Calgary.

—Reported by Sister M. P. Rheault, s.g.m., Calgary.

Mayor Don MacKay brought greetings from the city of Calgary.

Seated, left to right: Sister M. P. Rheault, Executive secretary-treasurer; Sister M. Geralda, 2nd Vice-president; Sister Maria James, 1st Vice-president; Reverend Sister M. Loyola, President; Dr. H. P. Wright, representative of the Associated Hospitals of Alberta; Reverend J. J. Flanagan, S. J., Executive Director of the Catholic Hospital Association of the United States and Canada, St. Louis, Mo.; Mrs. C. Van Dusen, R.N., Edmonton, Alta., bringing greetings from the Alberta Association of Registered Nurses; Reverend Francis J. Smyth, Director of Canadian Catholic Conference (English-speaking section) and Executive Director of the Catholic Hospital Association of Canada, Ottawa, Ont.; and the Reverend Francis MacKay, Bishop's Representative of the conference.

An interesting panel on important functions of good management in hospitals was directed by Sister Denise Marguerite, f.c.s.p., seen on far right.

Left to right: Sister Mary, administrator at St. Joseph's Hospital, Barrhead, Alta.; Sister Auchérie, administrator at St. Mary's Hospital, Trochu, Alta.; Sister Alice Gauthier, s.g.m., administrator at Edmonton General Hospital; Sister Levasseur, administrator at Bonnyville, Alta.

For Directors of Hospital Volunteers

A training and refresher course for directors of hospital volunteers is to be conducted jointly by the volunteer departments of the Montreal General and Royal Victoria Hospital, Montreal, P.Q., from February 17th to 28th, 1958. It is under an advisory committee headed by the Executive Directors, and arranged and presented by their Directors of Volunteers.

The course is open to anyone interested in becoming a Director of Hospital Volunteers or in establishing or sponsoring a Department of Volunteer Services, and might include other related hospital personnel, members of auxiliaries and community groups.

Qualifications for registration are university education or its equivalent in experience. Training should include some personnel, business or hospital experience. A genuine interest in people and the capacity for working successfully with them are important, as well as flexibility, patience, tact and the ability for leadership.

Studies in the course will be hospital administration, functions of the volunteer department, duties of the Director of Volunteers, and public relations.

Members of the hospital staffs will give lectures. Work shops, round table discussions and practical work will be included in the course.

Application forms can be obtained from the Director of Volunteers, The Montreal General Hospital, Montreal 25, or Royal Victoria Hospital, Montreal 2, and must be returned there not later than January 15, 1958. The registration fee is $50.

"Really, now you ask me," said Alice, very much confused. "I don't think—" "Then you shouldn't talk," said the Hatter.— *Lewis Carroll.*

Maritime Conference Meets at Moncton

THE 33rd annual meeting of the Maritime Conference of the Catholic Hospital Association of Canada, was held August 26-28, 1957, at Notre-Dame d'Acadie College in Moncton, N.B., with 22 of the 23 member hospitals of the Conference being represented. More than 70 delegates and guests were registered for this meeting.

Delegates convened at 4 p.m. on Monday, August 26, when the Convention was fittingly opened with Pontifical Mass in the College chapel, celebrated by the Most Reverend C. A. LeBlanc, Bishop of Bathurst. In the unavoidable absence of Reverend J. B. Nearing of Sydney Mines, spiritual director of the Conference, the sermon was delivered by Reverend E. Chiasson, resident chaplain, St. Rita Hospital, Sydney. In it was contained the inspiration and keynote theme of the convention—self-appraisal with a view to improved patient care—which was to permeate all the deliberations.

Sister Kerr, president, and her committee developed a program which was stimulating, informative and timely.

Dr. D. F. W. Porter, president of the Canadian Hospital Association, brought greetings from that body and presented a comprehensive and detailed report of the "Present and Proposed Activities" of the Canadian Hospital Association, in the interests of the hospitals of Canada. He made particular mention of the major issues on the hospital horizon at this time, such as the national health plan and an all-Canadian accreditation program. He stressed the need of developing strong associations at all levels — national, provincial, and local.

The accreditation of schools of nursing was covered very thoroughly by Sister M. Felicitas, director of nursing, St. Mary's Hospital, Montreal, in her paper entitled "Self-appraisal: the Keynote to Progress", which was the theme used by the parent association in this year's convention. Her presentation of this timely topic was provocative of lively discussion from the floor, and helped to show in true perspective the real purposes and aims of the accreditation program with reference to schools of nursing, "self-examination as a means of progress".

"Unionization of Hospital Personnel" was the topic treated by Reverend George Topshee, director of adult education, Xavier Junior College, Sydney. Father discussed this topic in the light of the social teachings of the Church, emphasized that the trend of labour toward organization must be recognized, and stressed the desirability of having our staffs organized.

A full session was devoted to a report of the special committee appointed at the previous convention to study "Certain Aspects of

Members of the executive board for the Maritime Conference of the Catholic Hospital Association of Canada, for the years 1957-1959, are: from left to right, (standing) Sister Catharine Gerard, Halifax, N.S., 1st vice-president; Sister Kerr, Vallée Lourdes, N.B., past president; Sister Leonie de Carmel, Moncton, N.B.; Sister Paul of the Cross, Antigonish, N.S., and (seated) Sister Kenny, Chatham, N.B., 2nd vice-president; Sister M. Clarissa, Sydney, N.S., president; and Sister Maria Josephine, Sydney, N.S., secretary-treasurer.

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Presiding at an afternoon session was Sister M. Clarissa, vice-president. Seen here, left to right, are: Rev. E. Chiasson, Sister M. Clarissa, Sister Kerr, president, and Mother Albert, secretary.

Among delegates to the Conference were, left to right: Sister Kerr, Vallée Lourdes, N.B.; Sister Mary Sylvia, Dalhousie, N.B.; Dr. D. F. W. Porter, representing the Canadian Hospital Association; Sister St. Joseph and Sister Marie Real, Dalhousie, N.B.

Christian Orientation in our Hospitals and Schools of Nursing." This report was presented by Rev. E. Chiasson, Sydney, chairman. The findings as reported were very interesting and out of the report there evolved many questions, comments, and suggestions for improvement in this particular area in our hospitals.

Full reports of the biennial meetings of the Canadian Hospital Association and the Catholic Hospital Association of Canada, held in Saskatoon in May, were presented by the delegates, Sister M. Kerr and Mother Albert. The proceedings of the Catholic Hospital Association Convention in Cleveland, were covered very completely in a report prepared by Rev. J. B. Nearing, who was the Conference's official delegate to that meeting, held last May also.

Officers for the ensuing year are: *President*, Sister M. Clarissa, Sydney, N.S.; *First vice-president*, Sister Catherine Gerard, Halifax, N.S.; *Second vice-president*, Sister Kenny, Chatham, N.B.; and *Secretary-treasurer*, Sister Maria Josephine, Sydney, N.S.

—Reported by Sister Maria Josephine

Pathologist

(continued from page 43)

made between what is hospital care and what is medical care. The Canadian Association of Pathologists has prepared a list of principles both for hospitals and for pathologists and for any third party which may be carrying the costs of the services.

The most important factor, of course, in any set of principles, is to make sure that the patient receives the highest possible standard of laboratory medicine. It is our aim and a matter of policy to do everything we can to provide patients throughout the country with a high standard of pathological service.

Medicine has progressed far enough today that there should be no question anymore as to the nature of pathology. Accrediting boards and courts of law have ruled that pathology is a specialty in the practice of medicine. It follows then, that the services performed by licensed medical practitioners in this specialty are medical services and not part of hospital care. In other words, a hospital having a pathological laboratory is actually offering its patients a medical service.

In order to ensure a high standard of service. it is imperative that a licensed physician, preferably a certified pathologist, should be in charge of each hospital laboratory. Even the smallest of hospitals, having a laboratory employing only one technician, should never impose the full responsibility of the operation of that laboratory on a technician. Instead, some member of the medical staff must assume responsibility for the operation of the laboratory. If the services of a pathologist are available in the immediate territory, then that pathologist can be engaged on a part-time basis to supervise the laboratory and be responsible for it.

It should always be remembered that pathologists are held responsible for the work of their technical laboratory staff. While technicians form a very important part of any laboratory, they are, as one authority has put it, "the hands of the pathologist" just as nurses might be called extra hands for the physician or surgeon.

Quality control of any medical service is a most important item. We pathologists have agreed that through the provincial branches of the Canadian Medical Association, we will assume responsibility for establishing standards to ensure the quality and accuracy of pathology as practised in Canada.

Payment of services

It has been shown above that the actual number of patients in a hospital bears no particular relationship, as a rule, to the activity and demands placed upon the department of pathology.

The number of procedures required per patient is determined, to a great extent, by the nature of the individual's illness and the

(concluded on page 86)

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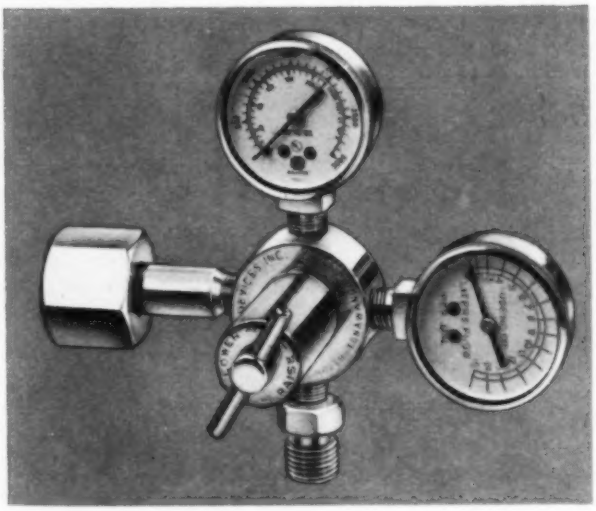

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Attitude of Hospitals

(continued from page 45)

short of the actual cost. The percentage paid to the radiologist or the pathologist is for interpretations made, for any portion of the work of the department which he himself would do and for his general supervision of, and responsibility for, the work of the department.

Emphasis on "ethics"

Hospital people and many physicians are puzzled over this continual stressing of ethics. It is not "unethical" for doctors to work on salary for insurance companies or industry. Although it is "unethical" for them to work for a hospital with a profitable department, it is quite all right to be on salary if the departmental income is low and the department runs at a loss. Nor is it considered unethical for a radiologist in charge of a large department to open an office in a medical building, divert most of the outside work there and give only part time to his hospital work. We hear much about preserving the free choice of physicians, so one could logically say, why not pay a radiologist or a pathologist for supervision, but let a doctor of the patient's choice interpret the findings?

It is hard to believe, despite considerable evidence, that the concern can be for a greater income, for the present net earnings of these specialties are quite high indeed. While Canadian figures are not available, the American figures for 26 selected specialties published in *Medical Economics* last October placed radiology in first place and pathology in fifth. The seven highest net earnings were for radiology, neurosurgery, orthopaedic surgery, plastic surgery, pathology, urology and gynaecology.

In 1939, a joint committee of the three radiological societies and the American Hospital Association (with the speaker as one of the two A.H.A. representatives) drew up an agreement the essence of which was a statement (Section 5) that could be applied equally well today:

"Inasmuch as no one basis of financial arrangement between a hospital and its radiologist would seem to be applicable or suitable in all instances, that basis should be followed which would best meet the local situation. This may be on the basis of salary, commission or privilege rental, but in no instance should either the hospital or the radiologist exploit the other or the patient."

The Iowa Act

Unfortunately, this agreement and comparable ones with the pathologists and the anaesthesiologists, gave place to other viewpoints. We had the *Hess Report*, followed by the much-quoted *Principles for the Conduct of Physicians in Relationship with Institutions* which includes statements respecting ethics which are not in accordance with the American Medical Association's *Principles of Ethics*. Various legal decisions have been made, notably the Iowa one. Following this last decision, which left the forgotten public nowhere, the medical and hospital associations worked out a compromise which has become a new Act. This Act places the laboratory and x-ray facilities under the hospital. Technicians and other non-medical personnel will be employees of the hospital, unless otherwise agreed, but the services of the departments are to be considered as medical services.

There may be "any provision for compensation" of the doctor in charge "upon which they mutually agree provided, however, that no contract shall be entered into which in any way creates the relationship of employer and employee between the hospital and the doctor, and a percentage arrangement is not and shall not be construed to be unprofessional conduct on the part of the doctor or in violation of the statutes of this state upon the part of the hospital."

It is too soon to venture an opinion as to whether or not this Act will provide a satisfactory solution; at least it clarifies some contentious points.

Bill 320

In the past few weeks the wording of the federal measure authorizing federal contribution to provincial programs for hospital insurance and laboratory and other services in aid of diagnosis has clarified official attitude in Canada respecting basic relationships.

The Hospital Insurance and Diagnostic Services Act, passed April 10, 1957, provides under "in-patient services", *inter alia*.

2 (*f*)

(iii) laboratory, radiological and other diagnostic procedures together with the necessary interpretations for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of injury, illness or disability.

Under (i), "out-patient services", the same item is included.

The "provincial law" required to warrant federal payment is "a law of the province that (a) makes provision for the furnishing by hospitals of insured services . . . " It would appear, therefore, that in the participating provinces radiology and pathology are now officially "hospital services".

Separation of Services

There is one solution which may be forced on hospitals but which would be a regrettable one. This might be necessary because the hospitals, operating as they do solely in the public interest, have no intention of omitting these vital departments from the services they are expected to provide to their patients. They believe that there must always be a close relationship between the hospital and these essential diagnostic services.

Should unfortunate legal decisions be sought and obtained which would make it necessary for hospitals to refrain from maintaining diagnostic services as now organized, I am quite certain that, in fairness to their patients and to the doctors on their staff, they would continue these departments on another, though less satisfactory, basis. That would be by separating the technical and the professional aspects of the work. They would provide the space, purchase and maintain the equipment and employ the non-medical staff—just as they do now for the operating room or the delivery room. That could not be construed as "practising medicine". They would appoint a consulting radiologist and pathologist; in fact, they could appoint several—just as they appoint several surgeons to the staff. The attending physician could then, if he so desired, ask for a consultation on the technician's findings or the films, or he could make his own interpretations. The internist would probably interpret the laboratory findings himself and the orthopaedic surgeon, urologist and chest physician would interpret the films himself. The consulting radiologists or pathologists would send their accounts directly to the patient just as would any other consultant. This would not be satisfactory to the radiologist nor to the pathologist, and probably not to most of the medical staff, but that would be the concern of those who have stirred up this unrest and agitation.

(concluded on page 84)

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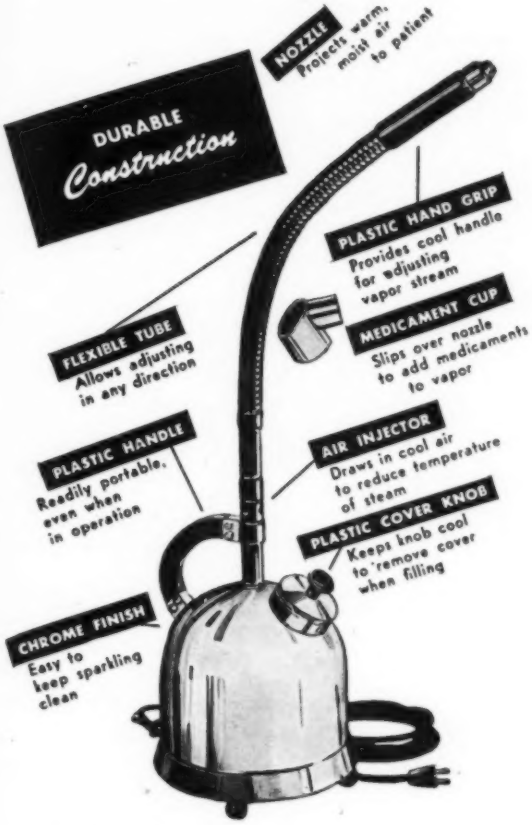

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Attitude of Hospitals

(concluded from page 82)

Actually, this basis of operation was tried out in radiology some years ago in a large American city. It resulted in so much reduced revenue to the radiologists that the Blue Cross in that area was asked to return to the conventional basis of payment.

In conclusion, the hospitals believe that the various differences, which have been largely magnified, can be settled amicably. They believe that the ultimate basis of remuneration will be the one most frequently followed now—that of percentage agreement. In pathology one can anticipate an increasing proportion on the percentage basis. The percentage should be a variable one, depending on various circumstances. We believe that one based on net, rather than gross, revenue can be just as remunerative but more conducive to economical operation.

It is realized that there may be problems resulting from charge limitations which, conceivably, could be set up under any program of hospital insurance. This would be of as much concern to the hospitals as to the specialty groups and I am quite certain that the hospitals will be very desirous of working closely with their pathologists and radiologists in effecting a mutually satisfactory solution.

Cloudy Terminology Defeats Purpose

The terminology of most professions is made up of various groups of words. Some are purely technical and are intended to convey fixed meaning. Training in a given profession includes the learning and use of its vocabulary. Some terms are borrowed from other disciplines in order to express similar concepts or facts. And there are other words which are "plain English". These words have an important place not only in communication with the layman and to a necessary degree with other disciplines, but in communication within the profession itself. In this area of "common words" the variation not only in individual use but also dictionary definition may result in confusion of intended meaning. Consequently careless use of loosely defined words not only defeats our effort to have others understand our concepts, but actual misinterpretation and erroneous information result. Granted, some of these terms may be acceptable between persons of the same professional background or training, but when a term is neither correctly interpreted nor used by others, it would seem obvious that it should be deleted from these levels of communication.—*Helen P. Le Vesconte, O.T. Reg., in The Canadian Journal of Occupational Therapy.*

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Pathologist
(concluded from page 80)

diligence of the physician or surgeon looking after the patient. Furthermore, as pointed out above, the trend is, in recent years, for more and more laboratory procedures to be performed for each patient. This is good and promotes better medical care. It seems reasonable, therefore, that payment for these pathological services should be on a fee-for-service basis, whether this payment be made directly by the patient or by a third party. Furthermore, fees should provide adequate coverage for all expenses associated with the provision and maintenance of a first-class pathological service. To be specific, the fees should be sufficient to provide enough income for the laboratory to look after the post mortem service, to conduct some investigation in the laboratory, to hold clinical pathological conferences, to teach interns, nurses and student technicians, to allow for the expense of working up interesting cases by means of photography and other methods. The fees should be of a sufficient nature to ensure that enough personnel is available to handle the work properly and accurately, and that they are compensated properly. These fees should be adequate to compensate the hospital for light, heat, power, space and any other costs involved in maintaining the laboratory.

In all fairness to the individuals paying the fees, the revenue derived from the clinical pathological services should be applied to those services alone. We have found that the pathology fee schedules adopted by provincial medical associations or some modification of those schedules, should be the basis for the charges for the services, since they take into account the needs of most laboratories.

It is not good practice, in fact the matter might be open to question, for an institution to offer the services of a medical practitioner and charge a patient for those medical services. Therefore we feel strongly that any billing for pathological services should include the name of the doctor concerned. If both parties deem it advisable, there may be included as part of the bill a statement as to what proportion of the charge reverts to the hospital for the non-professional services and facilities which have been provided by the hospital.

Finally, as there is today almost universal agreement that the services rendered by pathologists and by the pathology laboratory are medical services, we feel strongly that the fees or charges for these pathological services should be paid for as medical and not as hospital services. Hence it might be more proper for carriers of costs of medical services to pay for clinical pathological services rather than carriers concerned with providing for hospital services.

It is our hope that implementation of the above principles, which today are considered sound ones by thinking people, will establish well-defined working relationships between hospitals and pathologists, so that the clinical pathological services upon which good medical care depends will be enhanced and not compromised.

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Specialist Personnel
(continued from page 33)

new ones planned in the present program will be designed and located on the same basis. The over-all program includes an increasingly high standard of professional care and administrative practice, and calls for standards equally as high for the small as for the large institutions. Before one can share qualified specialist personnel they must first be obtained; and we are gradually obtaining ours by the three time-honoured methods, namely, on loan, by hiring, and by training. The sharing of existing specialized staff has been carried out by our group only on a limited scale in recent years but there are very definite plans for expansion of this phase of our program.

All four of the above systems were conceived on the *basis of need*, developed on the *principle of co-operation*, and administered under a *system of control*. All four actually work well, and all can be gradually or rapidly expanded. All four supply varying numbers of qualified specialist personnel to small hospitals.

For some years past, certain private firms and individuals have supplied specialist services to small and large hospitals, and there appears to be every reason to expect an expansion of this type of service to the smaller institutions. Providing such service on a fee basis is most democratic, and in certain instances at least the cost has been accepted by government agencies and third party groups as an acceptable expense as regards both construction and operating costs. A properly conceived hospital insurance program would make available to the small hospitals adequate funds to provide the staff required to operate these institutions at high professional and administrative standards. If such a program fails to produce the monies necessary to provide these high standards and to improve them to match the requirements of newer medical discoveries, then the public will have been cheated. In this particular regard, you will recall that the existing federal offer to the provinces states that the Federal Government will share neither in the financing of capital costs nor in the depreciation of the fixed assets. This lack of realism is a matter of acute concern to provinces, individual hospitals, and to hospital associations. In those hospitals financed in whole or in part by provincial or municipal funds this particular "exclusion" in the federal plan is not of too great moment, but it is of great concern to all *voluntary* hospitals both lay and religious. The Catholic Hospital Association of Canada and the Canadian Hospital Association have joint representation in the Federal Government in order to urge a correction of this absurd deficiency in the federal offer. To repeat, the "sharing" of personnel by small hospitals can be carried out only *after* we "acquire" them, and we can acquire them only if adequate funds are made available.

Let us now examine a list, which is at least partial, of those specialist personnel who can be shared by small hospitals, and even by what methods they are being actually provided today in some instances:

Radiologists—Sharing of members of this specialist group by small hospitals is now an accepted practice and must be more widespread in the future. The service

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B. C. Convention

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not enough facilities. Mr. Martin said he regretted that the introduction of the plan had been delayed due to lack of planning by the communities for the provision of beds for long-term patients. This is a matter of local initiative. It is estimated that one bed per thousand is required under the plan and since units of less than 30 beds are not economically sound, it is obvious that the area to be served should have a population of between 30 and 40 thousand persons before a chronic unit becomes feasible.

Mr. Martin detailed budgetary arrangements between the government and the hospitals. The whole picture is compounded in British Columbia because hospitals operate on a calendar year and governments on a fiscal year. A situation results where it is impossible to set per diem rates for hospitals until late in the spring. Mr. Martin said that he was fully aware of the shortcomings of this arrangement and that the government had tried to develop a system which would make the best possible adjustment.

During the past year, 57 hospitals in B. C. have had surpluses totalling $210,000 while 22 hospitals incurred deficits totalling $181,000. Thus total operating revenue for all hospitals exceeded expenditure by one tenth of one per cent. Mr. Martin stated that this reflected credit upon B.C.H.I.S. officials and administrators of the hospitals. The results indicated that the great majority of hospitals made an excellent and successful effort to operate within the funds made available.

Mr. Martin said charges had been made that hospitals had not been able to increase staff and thereby improve services. He pointed out that since hospital insurance began in 1949 the bed capacity of B.C. hospitals had increased 37 per cent. In the same period patient days had increased 50 per cent, and staff had increased by 80 per cent.

In answer to the complaint about "frozen" budgets, Mr. Martin referred to 1952 payments to hospitals which amounted to $21,309,964. Since then these payments had increased, he said, by over 50 per cent and now stand at an estimated $31,940,000. The minister said that certainly there had been the application of a "firm budget" principle, but that the people of B.C. through the Hospital Insurance Service are paying 106 per cent more for hospital service than they were nine years ago. Salary increases accounted for nearly 80 per cent of the over-all increase. In 1948 salaries and wages accounted for 60.6 per cent of the total cost of operation but, in 1957, this percentage was 71.

Employer-Employee Relationships

Two panel discussions were held on this subject. In the first, G. A. Little, supervisor, Vancouver office, Provincial Department of Labour, and J. T. Watt of Management Research (Western) Limited were the speakers. Mr. Little reviewed recent changes in legislation pertaining to the Vacation with Pay Act. Mr. Watt reviewed the field of employer-employee relationships as it exists in hospitals in B.C. today. Certain difficulties which arise from the operation of the Labour Relations Act were pointed out. Hospitals have to bargain separately with several groups of employees, such as stat-

(continued on page 94)

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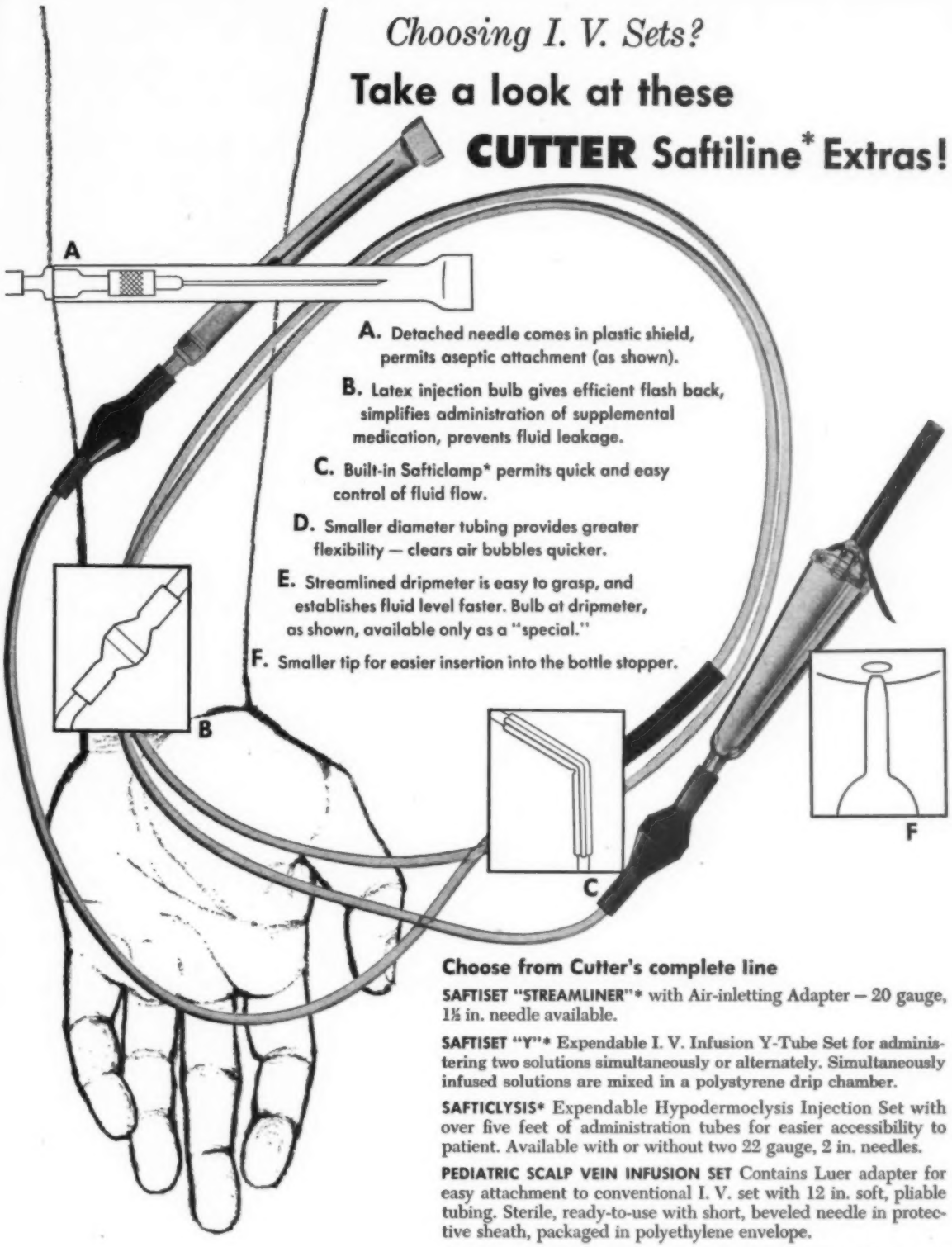

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B. C. Convention
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ionary engineers, nurses and craft unions. The speaker contended that conciliation boards at present are tending to bring in recommendations for higher wages than economic conditions warrant. It was Mr. Watt's opinion that unions have done a better job of organization than hospitals. It is essential that there be more collaboration and co-operation among hospitals on large negotiations under present circumstances.

The second panel discussion on this same topic consisted entirely of hospital representatives. Taking part were D. A. Thompson, representing St. Paul's Hospital, Vancouver; Fred Fisher, Vernon Jubilee Hospital, Vernon; W. C. Speare, M.L.A., G. R. Baker Memorial Hospital, Quesnel; H. R. Slade, Powell River General Hospital, Powell River; and Campbell Carroll, Royal Inland Hospital, Kamloops. Mr. Fisher contended that it is essential that bargaining with employers be carried out on a regional basis. Trustees need professional consultants — what is good for unions is good for hospitals in this respect. Mr. Slade believed management must sit down with employees at least once a year. There should be a strong personnel committee of the board of trustees, and it is essential that the board appoint an administrator who can handle all types of people. Mr. Slade also stated his view that the administrator should have the power of appointing all departmental heads.

Labour-management relationships, Mr. Speare stated, is a vital issue facing B.C. hospitals today, and collective action by hospitals in labour negotiations is essential. Goodwill with the individual employee must be established from the outset of employment. The importance of the initial interview, department head meetings, proper job evaluation, and avoidance of duplication in job performance — all were stressed by Mr. Speare.

Mr. Thompson believed the primary function of labour negotiations was to create a happy labour force for the hospital. There is a need for a change in existing legislation so that hospitals can bargain on a regional basis for all employees. The speaker also favoured the employment of a professional negotiator.

Mr. Carroll said it was essential to understand what the employee wants to accomplish and therefore management must consider employees individually.

In a panel discussion on patient care the subject, "What does the patient mean to you?", was discussed by Sister Carmichael, director of nursing at St. Joseph's General Hospital, Comox; Dr. S. L. Williams, Vancouver; J. L. Kitchen, a trustee of Trail-Tadanac Hospital, Trail; and Gordon Frith, administrator of Nanaimo General Hospital.

Dr. D. F. W. Porter, president of the Canadian Hospital Association, and Dr. W. Douglas Piercey, executive director, represented the national association at the convention. Dr. Porter reviewed the current financial picture of the C. H. A. and the executive director outlined current activities.

J. A. Abrahamson, Revelstoke, president of the British Columbia Hospital Association, 1956-57, said that the "tight" money policy of the provincial government towards hospitals has created many anxieties and problems for hospital

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B. C. Convention

(concluded from page 94)

boards. The deficit financing policy has aggravated the situation because a hospital does not know what its approved rate will be until the year is half over. Undoubtedly, the greatest cause of dissatisfaction among hospitals involves procedures concerning salaries and wages for employees, he said. Trustees cannot approach the bargaining table with an open mind but must approach it loaded with decisions made in advance by the government. While shackling hospital boards so that little discretion is left to them, the government refuses to accept any responsibility for the decisions arrived at, even though these decisions may be the result of arbitration which the hospital was compelled legally to accept.

Division Meetings

Several division meetings were held, including those of trustees, administrators, nurses, private hospitals, auxiliaries, and x-ray technicians. Reports of these sessions were presented at subsequent general sessions of the convention. Mrs. G. C. Chandler, chairman of the trustees' division, said that in order to make the work of the division effective there must be an easy exchange of ideas. Having visited 33 hospitals last year and attended 8 regional meetings, she believes the division has made much progress. Mr. Abrahamson paid high tribute to the work of the division under Mrs. Chandler's leadership. P. E. Russell, administrator of Queen Victoria Hospital, Revelstoke, and chairman of the administrators' division, said his group were wholeheartedly behind the proposal to expand the activities of the association. The administrators' news letter, which was circulated to all hospital superintendents, enabled a valuable exchange of ideas to be carried out at provincial level, and helped to maintain contact among hospitals.

C. J. Smalley reported for the private hospital division that 41 out of a total of 53 licensed private hospitals were members of the division. These represented some 1,350 chronic and convalescent beds.

Mrs. F. E. Atkinson, Summerland, president of the auxiliaries' division reported that they had raised $151,000 for hospitals during the past year. The president of B.C.H.A. spoke in appreciation of the auxiliaries' splendid voluntary efforts on behalf of the hospitals of B. C. and their patients.

The nursing division was represented by K. M. Bailey, superintendent of nursing at the West Coast General Hospital, Port Alberni, and J. T. Saunders reported for the radiological technicians. A great shortage of radiological technicians exists in British Columbia, and because there is an insufficient supply, some hospitals are employing untrained personnel, he reported. Mr. Saunders believes it would make for more stability if more men could be attracted into the field and indicated that the division is studying ways of improving the over-all situation.

Officers Elected

Hon. president: The Hon. Eric Martin; *Immediate past president*: J. A. Abrahamson, Revelstoke; *President:* L. F. C. Kirby, administrator, Royal Columbian Hospital, New Westminster; *1st vice-president:* J. H. D. Hargrave, chairman of the board, Trail-Tadanac Hospital; *2nd vice-president:* H. R. Slade, administrator, Powell River General Hospital.

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(continued from page 72)

A straight salary arrangement

The only advantage of this method of payment is that it provides a fixed amount per year for the fourth factor of cost of the radiological examination and hence is more adaptable to budgeting under an insurance scheme. The Section of Radiology and the Ontario Medical Association feel most strongly that this is not sufficient reason to allow radiologists to forfeit the fee-for-service principle and are categorically against it.

The disadvantages are many and work to the detriment of the patient. A few are: (a) exploitation of the rendered medical service by a third party such as a hospital so that some part of the fee for that service accrues to the third party as profit; (b) lack of incentive to the individual to render more service when required without added remuneration, surely a general human trait; (c) lack of uniformity of salary arrangements in Ontario at present. Even where this exists, as in British Columbia, it has not solved the problem of attracting enough radiologists to hospital work rather than private practice; (d) difficulty of obtaining capable and well-trained assistants when work-loads increase in a department.

Various types of percentage arrangements

The radiologist is paid a fixed percentage of either the gross or net income of his department with or without the addition of a salary. If a salary is paid under such an arrangement it is usually small and may well be regarded as remuneration for administration and general direction of the department. A certified radiologist is almost always an able administrator. His supervision of the non-medical personnel working under him is essential to the smooth functioning of a large establishment. If this work were done by a layman or a physician not trained in radiology, the work produced in the department would be of inferior quality.

The percentage type of arrangement is the basis for the majority of contractual agreements between hospitals and radiologists in Ontario today. Legislation recently passed in the state of Iowa recognizes it as an ethical method of arriving at a composite fee-for-service rendered by a radiologist. It could be easily applied to any contract between a hospital or other third party and a physician rendering radiological diagnostic services. The percentage must be adjusted in any individual case so that neither party exploits the other. This could readily be assured by arbitration of contractual agreements in dispute by a joint committee of the Ontario Hospital Association and the Ontario Medical Association. Another assurance that would be necessary in any such arrangement is that the percentage accruing to the radiologist must be based on the present Ontario Medical Association tariff for each individual examination performed in the department. A final control which should be borne in mind to ensure high quality work is the Canadian Association of Radiologists' recommendation that the case-load per radiologist per year should not exceed 7,000 to 10,000 cases depending on the type of case handled in the department.

The lease or rental type of arrangement

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(continued on page 102)

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Radiologist

(concluded from page 100)

the entire fee for the examination, hires and pays his employees, purchases all materials and reimburses the hospital or other third party for all costs incurred by them in providing space and equipment. This arrangement has been presented by the Ontario Medical Association in their brief to the Legislative Committee on Health of the Ontario government referring to diagnostic services. It is considered the ideal method of retaining the individual medical character of a radiological examination and is a certain method of preventing profit by a third party on the consultation inherent in such an examination. It is noteworthy that there are only two or three such agreements between hospitals and radiologists in Ontario. Its main advantage is that it sets the radiologist in the same category as most other physicians practicing in the province in that the entire cost of a consultation is included in the fee. It is frowned upon by those in hospital circles as approaching a monopoly.

The fractional professional fee

This system has not been attempted in Ontario but is being favoured in New England by both radiologist and hospital associations as a satisfactory compromise. The fee or charge for each examination is divided into a professional fraction to be paid to the radiologist and a non-professional fraction to be paid to the hospital to cover the first three factors detailed above in the cost of radiological examination. This can be regarded merely as a percentage arrangement applied to each individual examination. It would be of most value if the radiologist were paid by a prepaid medical plan such as Physicians' Services Incorporated. This is recommended by the Ontario Medical Association as the most logical approach to the whole problem of prepaid medical care and would allow for a gradual later inclusion of other medical benefits.

Coverage of costs applicable to hospital departments only

This is the inclusion of costs in an over-all daily rate for patient care. This method may be of great aid in the budgeting of an insurance plan but cannot have any application in the calculation of remuneration of radiologists or even of non-medical costs of operating the department of radiology. It would leave the hospitals in the anomalous position of trying to hold the number of radiological examinations to a constant figure unless the over-all daily rate were on a month-by-month sliding scale.

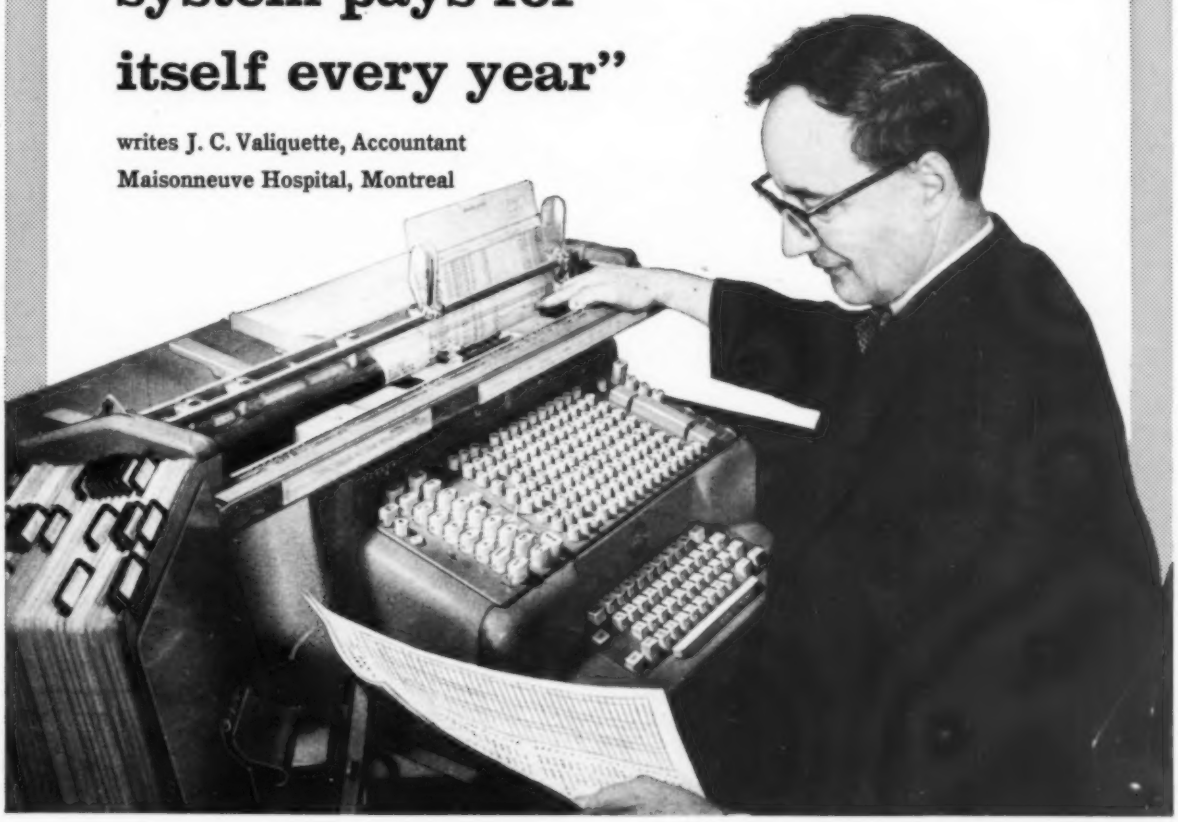
In conclusion, I would point out again that the patient's welfare is the factor we must consider first in all our discussion. Any restrictions or controls or any scheme of payment which lessens the patient's chance of obtaining the highest quality opinion from a radiological examination must be shunned. This can best be achieved by mutual study of every aspect of the problem by the representatives of government, of the hospitals, and of the medical profession, including representatives of our section. Only then can the best course be followed on many of the problems related to the launching of a universal insurance coverage for radiological diagnostic services.

New Hospital at Kilkenny

The new orthopaedic hospital at Kilkenny, estimated to cost about £300,000, and to be completed next spring, will contain ninety beds and go a long way to making Kilkenny one of the best equipped counties in Ireland as far as hospitals are concerned.—*Hospital and Health Management.*

"Our National system pays for itself every year"

writes J. C. Valiquette, Accountant
Maisonneuve Hospital, Montreal



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Resolutions

(concluded from page 53)

respect to granting provision in hospital estimates for the inclusion of costs requisite to enable hospital employees to become beneficiaries under the Unemployment Insurance Act, and to participate in contributory superannuation and health plans.

13. RESOLVED that the B.C.H.A. petition the government of British Columbia to give serious study, with a view to introducing legislation or amendments to present legislation, that will permit the government to establish "hospital districts" for the purpose of capital construction of hospitals or facilities, expansion or improvements by referendum on money by-laws by the land-owners of the established districts.

14. RESOLVED that the provincial government be asked to arrange for each hospital when requested, to be given an opportunity, in advance, to discuss fully with the Rate Board its annual estimates and the rate to be authorized each year.

15. RESOLVED that the B.C.H.A. be asked to take up with the training hospitals the means to provide for greater acceptance of students from outside communities,

and that the B.C.H.A. impress on all hospitals the dual responsibility of encouraging students to train for laboratory and x-ray work, and of interesting local organizations in provision of bursaries and loans to facilitate such training.

16. RESOLVED that the executive of the B.C.H.A. be fully informed of all budgeting and policy matters discussed between an individual member of the hospital association and the Hospital Insurance Service, and wherever possible a representative of the hospital association be present at the time of such discussions.

17. RESOLVED that the B.C.H.A. make representation to the Minister of Health requesting that he look into the whole matter of radiological technician training and supply, with a view to subsidization and extension of training facilities.

18. WHEREAS this association has been advised that the loss of employment caused by reactions to inoculations is not covered by the Workmen's Compensation Board.

THEREFORE BE IT RESOLVED that the executive investigate this situation and take such action as may be necessary.

...and you stand to save 25¢ of every dollar spent on washroom towels

IMPORTANT DISCOVERY: During the past year NIBROC* made an important discovery. We found that you can save up to 25% on the cost of washroom towels, at the same time getting the benefit of our WHITE, superbly soft Multi-fold kraft towels.

CUSTOMER-PROVED: To make doubly sure that this top quality NIBROC* installation actually saves money over so-called less expensive types, we tested it in washrooms across Canada in large and small installations.

A BET YOU CAN'T LOSE: Now we know we can offer institutions in general a bet they can't lose . . . a practical demonstration with measurable results. Let us show you why many of Canada's leading towel consumers are turning to NIBROC* quality washroom installations. Satisfaction or money back: if, after a reasonable trial period, your towel costs haven't been substantially reduced, you may return your cabinets for full refund.

NIBROC *MULTIFOLD* —**The only white kraft towel on the market. Chamois-soft—Extra absorbent—Extra wet strength—A sign of a discriminating user.**

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Twenty Years Ago

(From The Canadian Hospital, November, 1937)

The Fifth Congress of the International Hospital Association was held in Paris during July of this year, and it was the privilege of Father Verreault, the incoming president of the Canadian Hospital Council, and myself to represent Canada at this meeting. There were some thirty-four countries represented and about 650 delegates from these different countries were present. Fortunately, many of the countries, particularly those in Europe, sent larger delegations than we did from Canada. In representing the Canadian Hospital Council, which we were able to do without any expense to the Council, we took great pleasure in conveying to the Congress the felicitations and best wishes of the hospital field in this country.

You may recall that this body had its initial meeting in Atlantic City in 1929 in conjunction with the meeting of the American Hospital Association. It was decided to meet every two years, with post-graduate tours of European centres in the intervening years. At the next meeting in Vienna in 1931, the International Hospital Association was formally launched, with "Nosokomeion" as its official journal.

Every association convention has some special identifying characteristic. Some are attended because of the papers, others because of the demonstrations or inspections arranged. Some are attended for the good fellowship or for the inspiration. It is hard to evaluate the International because of the various factors involved, but, on the whole, I would feel that its chief advantage lies in the opportunity to bring about a greater understanding between the nations. Undoubtedly we could learn a tremendous amount from each other, but the language barrier, which is one of the greatest curses from which the world suffers today, makes it very difficult for us to get as much out of meetings of that nature as would seem possible.—*Dr. Harvey Agnew, Toronto.*

Brighter Waiting

The new out-patient department at Maelor General Hospital, Wrexam, offers a colourful decoration scheme, comfortable chairs, and tea for those waiting. — *Hospital and Health Management.*

Baker Memorial

(concluded from page 40)

third, loud-speaker system to operating room and main points. Further, the building is wired for an audio-telephone system planned for the future extension. This system will enable patients to speak directly with the nurse by means of a loud-speaker telephone fixture in the recessed bed lamp, with wall amplifiers for the nursing station, utility rooms and floor pantries.

The kitchen units, and most of the major equipment in the hospital, are of stainless steel, planned for permanent efficiency and long usage. Kitchen equipment for the present 50-bed capacity includes a large electric range, electric bake oven, peeler, mixer, automatic toaster, slicer, steam cooker, and dishwasher.

The laundry is designed for a close pattern of traffic in the form of a U. Soiled linen drops through a fire-proof aluminum shoot from the floors above to a sorting area at one end. It is then routed through the processes of washing, extracting, tumbling or ironing, to the linen repair area at the other end. The location of future equipment is provided for and indicated in the planned lay-outs.

The staff for the new establishment comprises two registered nurses and one ward aide on each floor for the day shift, and for the evening shift, one registered nurse with a third floating, and one ward aide for each floor; while at night only one registered nurse and ward aide are required on each floor. Certified nursing assistants were originally employed, but in this particular hospital it was considered best, in view of the occupancy rate, to use a second registered nurse on the floor rather than a nursing assistant. During the more active day shift there are a nursing supervisor, O.R. supervisor, and maternity head nurse on the nursing staff. There are two cooks and four general help in the kitchen, two in the laundry, two housekeepers, a steam plant engineer, maintenance man and janitor, an office staff of five as well as an x-ray and laboratory technician. Plans for the future extension include physiotherapy and occupational therapy departments and solarium as well as a chapel and quiet room. The end of the present corridor is purposely designed as a glass wall to enable ready extension.

The landscaping plans call for developing park-like grounds as convalescent areas, utilizing gentle grassy slopes. Native shrubs and small trees are used rather than ornate settings and flower beds which are difficult to maintain in this northern climate. Municipal authorities are encouraged to co-ordinate their park planning to achieve an over-all unified effect.

Amour Propre

When people say they do not care what others think of them, for the most part they deceive themselves. Generally they mean only that they will do as they choose in the confidence that no one will know their vagaries; and at the utmost only that they are willing to act contrary to the opinion of the majority because they are supported by the approval of their neighbours. It is not difficult to be unconventional in the eyes of the world when your unconventionality is but the convention of your set. It affords you then an inordinate amount of self-esteem. You have the self-satisfaction of courage without the inconvenience of danger.—*W. Somerset Maugham.*

You and Your Publics

(continued from page 42)

3. That it is operated without undue drain on community resources.

There are many ways in which you can reach this public — by press reports, by radio and television, by annual reports, by talks at service clubs, by open house visits, and by talks in schools.

Whatever medium you use, it is essential that your presentation should hold your audience's interest. Press reports and annual reports should be attention-attracting, talks should be interesting, facts should be dramatized, ideas and policies should be personalized and made to live rather than just be heard. For instance, if you are announcing that all patients are to be discharged by 2 p.m., explain that while it may be difficult for Joe Brown to leave his job at that hour to take his wife home, it is only in this way that Mary Dickson can enter hospital and have her tests done before her tonsil operation the following morning. Anyway, the hospital will not mind if Joe slips up a couple of hours ahead of time and takes his wife home during his lunch hour.

On the basis that one look is worth a thousand words, many people advocate open-house visits. On certain occasions it may be wise to allow visits of the general public to the hospital. One drawback with these visits is that the hospital finds it difficult to provide enough well-informed guides. To illustrate, before we opened our hospital in Peterborough*, it was decided we should have two days of open inspection. Hurriedly, we amassed nurses who had never worked in the building previously and gave them tours of inspection so that they could take visitors around the building. They were properly impressed with the vast amounts of stainless steel and modern furnishings. However, one nurse evidently hadn't been thoroughly oriented and in taking a group to the mortuary with its stainless steel fronted refrigerators she was heard to say in answer to a question on the purpose of the room, "Oh, that's a special kitchen".

Actually, it might be wiser, rather than to have mass visits in which little actual information about your hospital can be im-

**The author was formerly administrator of Peterborough Civic Hospital, Peterborough, Ont.*

parted, to have selected groups visit your hospital and have your experts give a thorough demonstration of part of your activities. One such group might be the teachers of your community. These people are interested in careers for their students and it might offer an opportunity to demonstrate to them the need for qualified personnel in your hospital. Most hospitals have difficulty in recruiting sufficient personnel. Even if you have no educational facilities in your own community or hospital, if you are able to interest young people in preparing themselves for hospital work, you have a better chance of having these people return to you than you have of attracting people who do not know the many good qualities of your community. Of course, it is easier for the large hospital to prepare interesting exhibits but in the small hospital you should not overlook the dramatic possibilities you have at hand. You may stage a mock operation showing the required draping, the number of instruments used, the personnel necessary, and the elaborate precautions necessary to maintain sterile technique. You can actually operate your autoclave putting in a test bundle considerably smaller than usual and illustrate how you check for sterilization. The cycle can be considerably reduced in time for test purposes. Maybe you can demonstrate how a new office machine saves you time. Your laundry operation may be of interest. There are many ways in which you can demonstrate and emphasize your continual effort to serve your patients well.

Finally, in any public relations program you must serve your community well. In this connection you must continually study the needs of your community for size of hospital and type of service required. You must study your relations with other organizations in your community. By making these studies public you will do much to make your community conscious of the hospital's importance in their scheme of things and to create a favourable climate for your proposals.

It is not true that suffering ennobles the character; happiness does that sometimes, but suffering for the most part, makes men petty and vindictive. — *W. Somerset Maugham* in *The Moon and Sixpence.*

Cariboo Doctor
1876 - 1953

It was cold. The Fraser River was slowing to a standstill, a few sluggish ice floes barely moving southward. There was no bridge the doctor could cross to reach the maternity case which called him to the other side, so he started to launch his canoe. An ice floe knocked it from his grasp and it skimmed away.

"Well, I had to get to that poor woman," he said, "so there was nothing for it but to swim after the canoe; I was soon in it and paddling across. When I got there my clothes clanked like a suit of armour. Someone hollered at me when I landed, 'Kinda cold weather for a dip, ain't it, Doc?' ".

The gleaming new G. R. Baker Memorial Hospital in Quesnel, B.C., stands to the world as a million-dollar monument to honour Dr. Gerald R. Baker, respected member of the College of Physicians and Surgeons and Honorary Life Member of the Canadian Medical Association. In London, England, where he was born, Dr. Baker studied at St. Bartholemew's under Dr. John Layton and Sir Henry Butlin. He studied medicine with Sir Thomas Lauder Brunton. Physician and surgeon, he kept pace with recent developments by frequent trips to Vancouver.

But it is Dr. "Paddy" Baker that the people of Cariboo loved. They felt the impact of the pioneer energy that brought him to this continent—to become a shotgun guard with the Wells Fargo Express, then a roving physician in the Yukon (who did a little placer mining on the side). He was assisting Dr. O. M. Jones in Victoria when he answered the call to become physician, surgeon, public health inspector, and impromptu veterinarian at Quesnel, in 1912.

It was a log cabin hospital that "Doc" Baker found. Light in the two-bed private ward and the six-bed public ward was unreliably provided by oil lamps. There was a room for the matron, but usually she slept in the hall so that her bedroom could be the maternity ward. In the pantry-sized operating room, the odour of cooking from the kitchen next door mingled with the smell of ether.

When Nellie English, the girl he married here, fainted at the first operation she witnessed, Doc Baker bunted her out with his feet because his hands were sterile. Soon she was assisting and giving anaesthetics. It was her job to ride after him, firing three shots, to tell him he was needed when "Doc" was hunting or fishing—the only tonic which relieved the pressure of exhausting work.

For 41 years Doc Baker was a living legend to the people of Cariboo. He cared for everyone—white, Chinese, or Indian. When his wise treatment brought fame and a stream of patients into Quesnel, they could still bring a sick dog to the busy physician. If the doctor was ever paid it was often in hay or hogs. Powerful, both physically and in his profession, Doc Baker is the source of stories of kindness, generosity, courage, and strength.

Even the mural in the reception room of the new hospital can do no more than suggest the impact of his life. The mural cannot show how cold that Fraser River felt. It can depict a doctor tending a patient in a remote log cabin, and racing to an emergency case, and treating a horse; but the fighting "Irish" of Dr. "Paddy" Baker, the spirit that lives on in the hearts of the people of Cariboo, is the same dynamic energy that built the new hospital at Quesnel.

You Were Asking
(continued from page 49)

so many later assignments are directed, I feel that I gained most from the very first few lessons.

As a comparative newcomer to Canada, with a background of hospital experience abroad, my purpose in taking the course was to find out in what ways Canadian hospital philosophy and function differed, if at all, from that which I knew; to find out, if possible, whether there were trends of thought and/or administrative practice which could be described as distinctly Canadian, and to which I must make personal adjustments.

These first few lessons, directed to philosophies and practices of management in general and related to hospital management in particular, I found to be invaluable. Together with the formal and informal association with students and faculty at the summer sessions, these lessons aided me most in my purpose, which was one of personal induction and orientation in the Canadian hospital field. — *W. O'Neill, Business Manager.*

Grants Brief

(continued from page 64)

able obstacle to the provision of much-needed facilities. Certain provinces of Canada have experienced a situation in the past whereby hospitals have been totally unable to raise any monies by public subscription. Although hospitals in some other areas have had a better public response, the already difficult task of raising funds by public subscription will not be made easier when a system of national hospital insurance becomes operative. Municipalities are reluctant to issue debentures or to guarantee bond issues to provide substantial sums for hospital construction because of high interest rates.

The formula of a set sum of money towards the cost of constructing a hospital unit such as "a bed", makes no provision for relating the amount of the grant to the actual cost. The grant was a very important factor in planning the financing of hospital construction when it first became operative, and the stimulus which it provided was apparent. However, as the cost of construction has mounted, the relative significance of the grant and the stimulus provided by it have progressively diminished.

We believe that a much higher percentage of the capital funds required for hospital construction should be provided by senior governments. Without a substantial increase in capital funds made available for this purpose, we fear that the facilities required for good standards of hospital care in Canada, in the immediate future, will not be provided.

The regulations governing the hospital construction funds grant state that the federal contribution "shall in no case exceed one-third of the actual cost". We believe that a formula for providing hospital construction funds whereby approximately one-third of the cost would be met by the federal government, one-third by the provincial government, and one-third by local sources, would be equitable even though it would, under present circumstances, require the raising of substantially greater funds from local sources than was the case when the grants were introduced.

We respectfully recommend that the amount contributed by the Government of Canada to each hospital construction project be equal to approximately one-third

(concluded on page 126)

Saskatchewan

(concluded from page 58)

expressed that the regional councils were financed solely by their member hospitals and that their activities were directed entirely to improving hospital services and that, therefore, they should enjoy the same privileges in respect to sales tax as do the hospitals themselves.

Hospitality

Through the courtesy of the Sisters, the delegates to the annual meeting attended an informal reception on the first evening of the meeting in the beautiful solarium of the Regina Grey Nuns' Hospital. Registrants for the Institute were tendered a buffet supper with the compliments of the Regina General Hospital.

In his first public appearance since his appointment as Chief Justice of the Court of Queen's Bench, Chief Justice Emmett Hall addressed the annual banquet of the association. The Chief Justice has long been associated with the lay advisory board of St. Paul's Hospital, Saskatoon, and has been identified with the activities of the Catholic Hospital Conference of Saskatchewan and the Catholic Hospital Association of Canada.

Commenting on the problems created by the inflated cost of hospital construction and hospital operation, the speaker suggested that it was a matter of placing "first things first" and that if the public wanted a first-class hospitalization program, on a provincial or a national basis, they would have to pay the price. "I think the people of this country are prepared to pay the price", commented the Chief Justice.

New Officers

Following the presentation of the report of the Nominating Committee by Herbert H. Bassett of Prince Albert, Charles E. Barton of Regina was elected president of the association, to succeed Eugene F. Bourassa who, as immediate past-president, remains a member of the Executive Committee. Michael F. Kushnir of Canora was elected vice-president of the association.

After a lively session of balloting for the membership of the executive, the following were elected: William O'Neill and Dr. Arnold L. Swanson, both of Saskatoon, to represent hospitals of over 100 beds in size; and Norman A. Hall of Shaunavon, William C. Hibbert of Wadena, and D. Z. Daniels of Canora, to represent hospitals of less than 100 beds in size. The executive director of the association is Philip Rickard with offices located at 1824 Scarth Street, Regina.

New Canadians

(continued from page 54)

parts of the world and our supermarkets must be confusing to the uninitiated. In most communities, too, there are excellent courses conducted by schools and University Extension Departments. Perhaps we could encourage more people to go to night school and cooking classes.

Some countries distribute excellent material to prospective emigrants on Canadian foods, comparing them to their own. This practice is to be commended. However, there is still a need for us to study how we, in this country, can best help the newcomer establish a good pattern of eating.

REQUIREMENTS CONTROL OFFICER

required for

Indian and Northern Health Services
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Ottawa.

$6,210 - $6,660

Applicants must be university graduates preferably with training in pharmacology or chemistry. They should have thorough knowledge of medical, surgical and other types of hospital supplies and equipment, and ability to provide consultant and advisory service in relation thereto.

For Details, Write To

CIVIL SERVICE COMMISSION, OTTAWA

Please quote competition 57-649.

CONSULTANT IN HOSPITAL ADMINISTRATION

required for

Health Insurance Division
Department of National Health and Welfare
Ottawa.

Candidates must be university graduates preferably with specialization in Economics, Commerce, Business or Public Administration. They should also have a post graduate degree in Hospital Administration or an equivalent combination of training and experience and demonstrated capacity to serve as a consultant on Hospital Administration and Health Insurance Programs.

For Details, Write To

CIVIL SERVICE COMMISSION, OTTAWA

Please quote competition 57-648.

Specialist Personnel

(concluded from page 90)

can be supplied on a fee basis by a private radiologist, or on a co-operative basis under either one of the four plans for integrated hospital systems.

Pathologists — The remarks I have made concerning radiologists apply equally to pathologists. If existing experience is a pattern for the future, "mail order" pathological services appear to be inevitable for the smaller institutions.

Dietitians—They can be shared on a consulting basis as a private fee arrangement, or under any of the integrated systems.

Accountants—By tradition, this service has remained almost exclusively in the private field, although instances exist whereby they are provided under an integrated system.

Medical Directors—This relatively new trend is still predominantly in the private field, but they are easily made available under an integrated system.

Pharmacists—I know of no actual instance of small hospitals sharing a pharmacist, although some small hospitals today employ a private pharmacist in the town to supervise the hospital pharmacy on a part-time basis. There is a very urgent need for these specialists to be made available on a consulting basis either under an integrated system or by private fee arrangement.

Bacteriologists, and Senior Technicians—There exists a crying need for these specialists to be made available to small hospitals on a regular and continuing basis particularly in a supervisory capacity. It would appear that an integrated system might offer the best solution to this problem.

Nursing Specialists—This category might well provide consulting services as follows: staffing advice; minimum standards for routine procedures; techniques in such special departments as central sterile supply, operating room, delivery room, newborn nursery, and paediatrics. Here, again, it would appear that an integrated system might best provide the solution to these requirements.

Engineers—Too few hospitals of any size seem to realize the importance of an adequate program of preventive maintenance of technical equipment of all types. Furthermore, as a general statement, the smaller the hospital the worse the preventive maintenance. A system of consulting and supervisory service is an urgent matter for our smaller hospital. The need would appear to centre on electrical and mechanical engineers, although the services of a sanitary engineer would be useful in many institutions. All types could well be provided by an integrated system, and I personally feel the time to be ripe in this area also for such services to be provided on a fee basis by a wide-awake firm of engineers or architects.

Like Parrots

I have been plagued all my life by scientists, clergymen, politicians and even lawyers, who talk like parrots, repeating words and phrases picked up from one another by ear without a moment's thought about their meaning, and accept mere association of ideas as an easy substitute for logic. — *George Bernard Shaw.*

LEUKOPLAST.....

THE IDEAL ADHESIVE TAPE

WATER-REPELLENT
WHITE OR FLESH
LIGHTWEIGHT TEXTURE
EXTRA STRONG
LONG STORAGE LIFE
RESISTS TEMPERATURE CHANGE
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ORIGINAL Beiersdorf PRODUCT **SYMBOL OF QUALITY**

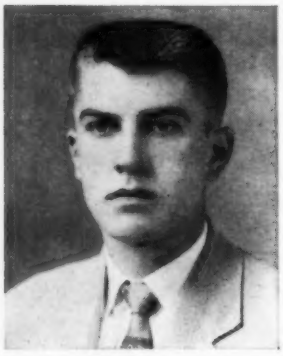
A-L 12

News Released by Hospital Supply Houses

By C.A.E.

John Jones is G. A. Hardie Appointment

John Jones of J. M. Jones & Son Limited, Moncton, N.B., has just completed a three-week familiarization program at G. A. Hardie & Co. Limited, head office, plant and warehouse in Toronto.



John Jones

Mr. Jones joined his father's firm in May of this year after three years at Horton Academy of Acadia University. He was born in Saint John, N.B., and educated at Moncton. He has taken up residence in Halifax, N.S., and will carry the Hardie line of Super-Weave textiles to hospitals, launderers, hotels, motels, institutions and industry throughout the province.

New Home for Professional Tape Company

An attractive new home of Professional Tape Company, Inc., in Riverside, Illinois, was opened in September, according to Mr. John Nerad, president.

These offices are designed to offer greater departmental efficiency for better customer service. In addition to the billing, advertising, production and shipping departments, a new safety department will feature a complete library on infections among personnel in hospital and laboratory.

Constant research in this field is conducted by the head of the department, Dr. Kenneth J. Costich, M. D. and pathologist. Analysis and interpretation of hospital and laboratory infections are studied and the results released in periodical papers. These papers cover the dangers of hepatitis and other infectious diseases. They seek a combined effort to eliminate these infections. This research work is in constant progress in conjunction with the American Hospital Association, the Blood Bank Association, the American Medical Technologists, the National Institute of Health Standards and other laboratory and hospital standards.

"Standard labeling systems can do much to eliminate much of the hand-to-mouth disease distribution", Dr. Costich said.

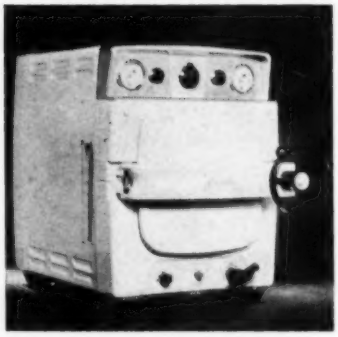
"High Fashion" Autoclave Added to Wilmot Castle Line

Fresh new style is the keynote of a new portable autoclave designed for medical and dental offices, according to the manufacturer, Wilmot Castle Co. of Rochester, New York.

Known as the Castle 999, the new unit is finished in heat-resistant, oven-baked enamel, and is available in three attractive pastel shades: Jade Green, Coral, and Silvertone. The coloured exteriors—plus a general softening of usual autoclave angularity — represent the fulfillment of the manufacturer's attempt to combine attractive design with efficient operation.

The "999" has no protruding valves, piping, tanks or spigots. Absence of the common steam-sterilizer "hardware" is possible because the sterilizing cycle is governed by a single-handle dial control. All functions—filling, standby service, sterilizing and venting are controlled by this single handle.

Double shell construction provides standby steam for immediate use in sterilizing, and the unit's initial steam build-up time is the fastest yet in any such portable autoclave.



The "999"" has a variable pressure regulator which provides for optimum sterilizing time-temperature conditions. The operator may vary the internal pressure from 7 to 27 p.s.i. (230°F. to 270°F.), as necessary for the type of load being processed.

Safe operating conditions are assured by a pressure safe door, which cannot be opened until all pressure is eliminated from the sterilizing chamber. The ""999" weighs 77 pounds and is 24⅝" long, 14-3/16" wide, and 19⅛" high.

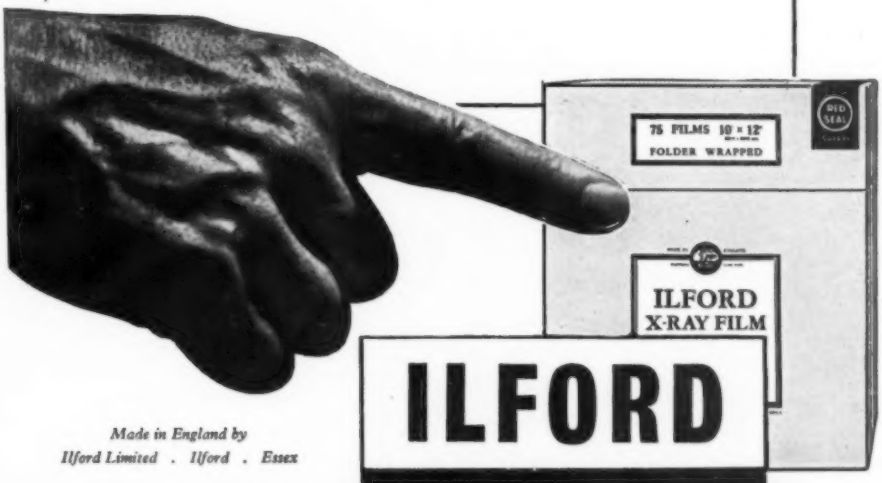
For further information, write to Wilmot Castle Co., 1901 East Henrietta Road, Rochester 3, New York.

Self-Powered Food Conveyor

A new concept in hospital food conveying equipment—self-propulsion for easy handling—was introduced by S. Blickman, Inc., at the 1957 American Hospital Association Convention in the form of the Touch-n-Go Foodveyor, a self - powered variable - capacity food conveyor. The Touch-n-Go power feature provides, it is claimed, the first practical way

(continued on page 124)

"We prefer
this high-speed film for
routine radiography too"



Of the many advantages to be gained from the use of Ilford Red Seal X-ray film, none is of greater significance than the very considerable reduction in radiation exposure made possible by the availability of such an extremely high order of sensitivity. As a screen-type film of unrivalled speed, Red Seal is at the same time outstanding in its consistently high quality and all-round performance. Thus, far from being a film to be reserved merely for occasions when purely technical considerations make high speed desirable, it is eminently suitable for routine use, giving radiographs of excellent diagnostic quality while minimizing radiation hazards to subject and operator alike.

Made in England by
Ilford Limited . Ilford . Essex

Sole Distributors:
W. E. BOOTH CO., LIMITED
Toronto • Ontario

ILFORD
Red Seal X-ray film

Across the Desk

(continued from page 122)

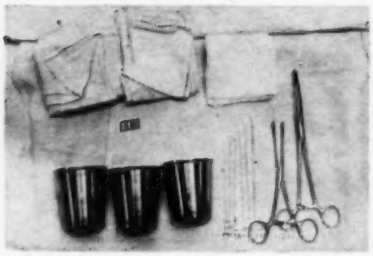
to overcome serious food service problems such as high labour costs, dependence on male custodial help, and slow meal distribution.

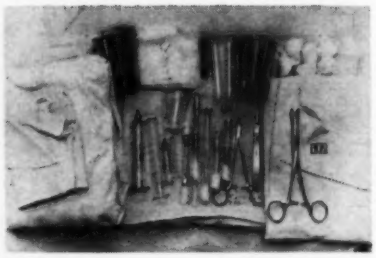
With a touch of her finger, a female employee can guide a fully loaded unit up or down ramps and

through constricted spaces such as diet kitchens, narrow corridors, and elevators, as well as on level floors. This ease of movement, the company states, allows the hospital dietetic department to cut labour costs by decreasing the number of employees required to move food conveyors, eliminate dependence on male custodial help, reduce the total number of conveyors needed by using units with greater weights and capacities, cut load on elevators by running fewer conveyors per meal, speed up patient meal distribution by reducing demand on elevators and eliminating tie-ups on ramps and in constricted areas, and to reduce accidents because the employee walks ahead of the conveyor, instead of pushing from behind, and can see any obstruction or person in the path of the unit.

The Touch-n-Go Foodveyor consists of a stainless steel Hot-and-Cold Foodveyor with an integral battery-powered motor that drives a fully loaded conveyor, weighing over 600 lbs. at approximately 2 miles per hour forward and ½ mile per hour in reverse. A fully loaded conveyor will move up or down a rise of 1 ft. in 20 ft. under complete control, without gaining any appreciable momentum on down-grades. The conveyor is designed to fit easily into all standard elevators. Its uniform speed and easy handling allows the Touch-n-Go Foodveyor to move quietly.

Further particulars available from the Canadian distributors: Wrought Iron Range Co. Limited, Toronto.





Revised Edition of Sterile Tray Index Now Available.

Just released for distribution is a revised edition of "Sterile Tray Index for Hospitals". It has been compiled by Florence Donohue, R.N., Central Supply Supervisor, Kitchener-Waterloo Hospital, Kitchener, Ont.

When the first issue of this brochure was distributed it was largely an experiment. The wide acclaim which has followed its publication has made five printings necessary. Illustrations have been added where it was regarded as important, to facilitate a better understanding by the hospital lay worker.

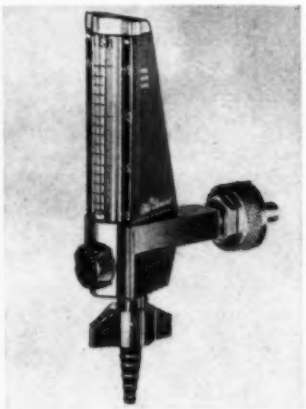
It is recognized that the index comprises basic material only. Each hospital will have variations which must be followed. However, the basic information given here should be most helpful and individual indices can be built around it when the hospital prefers to do so.

Illustration No. 113 shows Prep. Tray, Sterile, and No. 117, Sternal Puncture Tray.

The Index has been made available through the co-operation of Wilmot Castle Company, Rochester, New York, and the Stevens Companies, Toronto.

Ohio Pressure Compensated Flowmeter

A new, pressure compensated flowmeter, for use in all types of inhalation therapy including aerosol administration, has been designed by the Ohio Chemical and Surgical Equipment Company (A division of the Air Reduction Company, Incorporated) Madison, Wisconsin.



Indication of actual flow on the Ohio Flowmeter is almost unaffected by downstream restrictions such as those caused by diluters, humidifiers, or nebulizers. The new flowmeter can be quickly and easily adapted for use with single stage regulators on cylinders, or on pipeline installations.

The Ohio Flowmeter (body, needle valve, and connective means) is made of high strength forged brass. The scale is calibrated to 15 LPM oxygen, and has a "flush" position for use with tent therapy. Further information on this new pressure compensated Flowmeter may be had by writing to Ohio Chemical Canada Limited, Toronto, for their Form 4772.

Air-Shields NRB Head for Jefferson Ventilator

Air-Shields' new NRB (NonRe-Breathing) Head, fitting any model of the Jefferson Ventilator, for the first time makes possible mechanical ventilation with intermittent negative and positive pressures during non-rebreathing anaesthesia techniques. The valves of the NRB Head are clearly visible at all times, and the anaesthetist may resort to manual control of the rebreathing bag whenever it may appear desirable to do so.

The Air-Shields NRB Head is shown fitted to the new GH-3 Volume-Indicator model of the Jefferson Ventilator which is distinguished by a bellows-type internal rebreathing reservoir and unique conversion chart for more pre-

(concluded on page 125)

Incubator rides safely on Bassick casters

This new incubator features unusually convenient facilities for infant care.

That's where the sturdy Bassick casters with wing type wheel brakes come in. For smooth safe rolling they just don't make a better caster. They're easy-swivelling and quiet. The brakes guard against any accidental or undesired rolling or moving. And Bassicks protect hospital floors, never mark or gouge them.

For hospital beds, specialized method of application now available.

For miscellaneous use, the widest range of sizes and types for all purposes.

For laundry carts, service trucks, etc. "Diamond-Arrow" casters provide easiest action.

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Coming Conventions

Dec. 4-7—Maritime Institute on Hospital Finance, Brunswick Hotel, Moncton, N.B.

Dec. 9-13—A.H.A. Institute on Planning a Personnel Development Program, Edgewater Beach Hotel, Chicago, Ill.

Grants Brief

(concluded from page 114)

of the total cost. It is suggested that this might be accomplished most effectively through a modification of the formulae upon which the grants are calculated. Based on present construction costs and the existing "per bed" formula, the grant would amount to an approximate average of $4,500 per bed, or bed equivalent.

We believe that the best quality of hospital care can be most effectively secured by maintaining our system of voluntary hospitals in Canada. We do not believe that local communities should shift their entire responsibility for hospital facilities to provincial or federal governments. It is recognized, nevertheless, that the health of the people of the nation is a matter of national interest and that health administration is the constitutional responsibility of the provinces.

The hospital construction grant recognizes this tri-partite interest and responsibility between federal, provincial, and community authority. We heartily endorse the *fundamental* principle of the program. At the same time, we urge that a thorough review of the existing regulations with a view to initiating modifications, based on experience and in the light of future needs, would be in the public interest.—*D. F. W. Porter M.D., President.*

Insurance Brief

(concluded from page 35)

tional hospital insurance has been introduced, a campaign for funds for future construction will be of doubtful value. A campaign to raise funds to retire existing capital debts will be completely unsuccessful and needs no comment.

In Sisters' hospitals the salaries allowed for the services of the Sisters can be used. This is a small item in relation to the total budget of a hospital and for a capital debt of any size is completely inadequate. For the lay voluntary hospital this source of funds does not exist.

Although this question is of primary interest to voluntary hospitals, it has implications for municipally owned hospitals as well. Reimbursement of part of the capital cost of hospitals by the federal government under the national formula would lessen the tax load on the municipal taxpayers. Since municipal property taxes in most parts of Canada have just about reached the saturation point, relief in this area would be most welcome.

The Canadian Hospital Association respectfully urges reconsideration of the announced basis for the contribution of the federal government to the cost of hospital care and would request you, as Minister of National Health and Welfare, to take leadership in pressing for the inclusion of depreciation and interest charges as current operating expense in hospitals. We sincerely believe that any other basis of payment will eventually endanger the system of voluntary hospitals in Canada and create an undesirable and unnecessary problem in the replacement and expansion of hospital facilities in the future.—*J. Gilbert Turner, M.D., President.*

C.A.M.R.I.

(concluded from page 28)

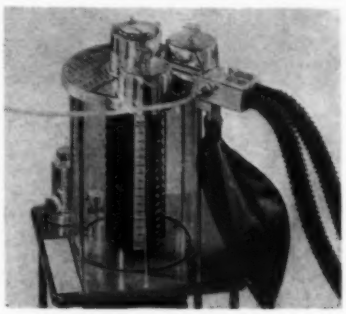
of opinions and ideas was the garden party arranged by the Sisters of St. Joseph in the grounds of St. Joseph's Hospital on Wednesday afternoon.

The annual meeting for 1957 closed with an executive meeting at which the new slate of officers prepared their agenda for the coming year. These new officers are: *President*, Dr. Margaret McGuire, Winnipeg General Hospital, Winnipeg, Manitoba; *President-Elect*, Frances Wilson, Sudbury Memorial Hospital, Sudbury, Ontario; *First Vice-President*, Sister Mary Catherine, St. Joseph's Hospital, Victoria, British Columbia; *Second Vice-President*, Alice Rublee, University Hospital, Saskatoon, Saskatchewan; *Secretary*, Nan Rackham, The Children's Hospital of Winnipeg, Manitoba; *Treasurer*, Mrs. Verona Noble, Winnipeg General Hospital, Winnipeg, Manitoba; *Councillor*, Claire Cooper, Vernon Jubilee Hospital, Vernon, British Columbia. — *Reported by Mrs. C. Plenderleith.*

Across the Desk

(concluded from page 120)

cise estimate of tidal exchange under various gas flows and rates of respiration.



Information about the new NRB Head and model GH-3 Jefferson Ventilator may be had direct from Air-Shields (Canada) Ltd., 8 Ripley Avenue, Toronto, Ontario.

Lederle Research Fellowship Awards

The awarding of eleven Lederle of Canada Research Fellowships for study at universities in Nova Scotia, Ontario, Quebec and Saskatchewan has been announced by Joel R. Brown, Jr., manager of Lederle Laboratories Division, North American Cyanamid Limited.

Names of the fellowship winners and their fields of research follows: at Dalhousie University — Gerald Berry of Montreal, pathology, and W. P. Warren of Halifax, pharmacology; at the University of Ottawa—Marc Colonnier of Ottawa, anatomy, and Anita Jakerow of Ottawa, pharmacology; at the University of Toronto—Donald R. Hopkins of York Mills, physiology, and Harry Schachter of Toronto, physiology; at the University of Western Ontario—Norman A. Fretz of London, physiology, and Kathleen M. Sandor of London, biochemistry; University of Montreal—Christian Lamoureaux of Montreal, biochemistry, and Yves Langlois of Cartierville, physiology; University of Saskatchewan — Suzanne Yip of Saskatoon, biochemistry.

ERROR

Due to the fact that the front pages of this issue of the magazine were printed early, there is an error in the

FISHER & BURPE LIMITED

advertisement which appears on page 6

The correction is:
No. 97 Stryker Shower Shield $4.50 per doz. (sales tax extra)